Term	Acronym/ abbreviation	Definition
		aged care needs assessments with older people and will be required to exercise clinical judgement.
Commonwealth Continuity of Support Programme	CoS	The Continuity of Support Programme has been replaced with Disability Support for Older Australians (DSOA).
Commonwealth Home Support Program	CHSP	The Commonwealth Home Support Program provides a broad range of entry-level support services to assist older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people and people who are homeless or at risk of homelessness) to live independently in their homes and communities. From 1 November 2025, the CHSP comes under the *Aged Care Act 2024*.
Comprehensive assessment		An assessment type for people with more complex needs. Comprehensive assessments are undertaken by clinical assessors.
Cultural Safety for Aboriginal and Torres Strait Islander people		The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) defined cultural safety as: 'Cultural safety requires understanding 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

Term	Acronym/ abbreviation	Definition
		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' According to the Australian Health Practitioner Regulation Agency (AHPRA): "Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities." It involves ongoing critical reflection by health practitioners on their own knowledge, skills, attitudes, and power differentials, and how these affect their practice
Departmental delegate		A departmental employee whose position has been delegated powers and functions under a section of the *Aged Care Act 2024* (Cth) by the System Governor.
Disability Support for Older Australians	DSOA	DSOA 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.
Elder Care Support Program		This workforce helps older Aboriginal and Torres Strait Islander people, their families and carers, to access aged care services across urban, regional and remote Australia to meet their physical and cultural needs.

Term	Acronym/ abbreviation	Definition
Aboriginal and Torres Strait Islander Assessment Organisations	FNAO in My Aged Care System	Aboriginal and Torres Strait Islander Assessment Organisations were established from August 2025 to provide culturally safe, trauma aware and healing informed assessments.
Formal Services		Where formal services are referred to in this Manual these are paid services, such as government funded support.
Good Practice / Best Practice		Good practice is a matter of action. Best Practice is a recommendation.
Home modifications	HM	Changes to an older person's home to create a home environment that is safer and more accessible, so they can remain living safely at home.
Home Care Package Program	HCP	The HCP Program supported older Australians with complex care needs to live independently in their own homes. There are 4 levels of s — from level 1 for basic care needs to level 4 for high care needs. The Program ceased on 31 October 2025, replaced by the Support at Home program.
Informal Services		Where informal services are referred to in this Manual this is the unpaid support provided by carers, family, neighbours or other community organisations.
Integrated Assessment Tool	IAT	The IAT is an assessment tool used to assess eligibility for all aged care programs.
ISBAR		The ISBAR framework represents a standardised approach to communication which can be used in any situation. It stands for Introduction, Situation, Background, Assessment and Recommendation. The ISBAR is the format which must be used when drafting a Support Plan.
Multi-Purpose Service Program	MPSP	The Multi-Purpose Service Program (MPSP) is a joint initiative of the Australian Government and state and territory governments. It aims to deliver flexible and integrated health and aged care services to some small rural and remote

Term	Acronym/ abbreviation	Definition
		communities that could not viably support stand-alone hospitals or aged care facilities.
My Aged Care contact centre	The contact centre	The My Aged Care contact centre is the starting point to access Australian Government-funded aged care services. The Freecall phone line (1800 200 422) and website https://www.myagedcare.gov.au/contact-us can help older Australians, their families and carers to get the help and support they need.
My Aged Care service provider and assessor helpline	Helpline	My Aged Care service provider and assessor helpline (1800 836 799) is the industry helpline for My Aged Care portal issues. They provide a reference number to track the progress of a complaint or issue and notification when the ticket is closed. Issues can be escalated to other teams within the department as appropriate. Call from 8am to 8pm Monday to Friday or 10am to 2pm Saturday.
My Aged Care Workforce Learning Strategy		The My Aged Care Workforce Learning Strategy 2025 (Workforce Learning Strategy), and subsequent editions of this strategy defines and sets the minimum training requirement for the Single Assessment System workforce and the My Aged Care workforce, including timeframes for completion. The My Aged Care Assessment Workforce Learning Strategy can be found at this link.
My Aged Care Learning Management System	MAClearning	The delivery of training to the My Aged Care Workforce organisations occurs via the My Aged Care Learning Management System (MAClearning). MAClearning provides assessors with: • access to mandatory and optional online learning, • information about mandatory appraisal activities, and • a record of all completed learning and appraisals

Term	Acronym/ abbreviation	Definition
My Health Record	MHR	My Health Record is a secure online summary of key patient health information. Healthcare providers can access the system to view and add information.
National Aboriginal and Torres Strait Islander Flexible Aged Care Program	NATSIFAC	The National Aboriginal and Torres Strait Islander Flexible Aged Care Program funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. These services are mainly located in remote and very remote locations.
National Disability Insurance Scheme/Agency	NDIS or NDIA	The NDIS provides support for people with disability, their families and carers in Australia. The NDIS will provide all Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life. This may include personal care and support, access to the community, therapy services and essential equipment.
Non-clinical aged care needs assessor	Non -clinical assessor	An 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 non-clinical assessor undertakes simple (home support) aged care needs assessments with older people.
Prescribed assistive technology		Assistive technology that would benefit from a prescription from a suitably qualified health professional.
Privacy Act 1988	The Privacy Act	The *Privacy Act 1988* applies to the collection, retention and use of personal information by assessors and regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information and access to and correction of that information.
Progressive condition		A medical condition that worsens over time, resulting in a range of limitations in function which can affect quality of life, daily living and community activities. (The 13 conditions listed

Term	Acronym/ abbreviation	Definition
		below are all eligible AT-HM progressive conditions under SaH). These conditions include: • Cerebral Palsy • Epilepsy • Huntington's Disease • Motor Neurone Disease (MND) noting different phenotypes require different management • Multiple Sclerosis (MS) • Parkinson's Disease • Late effects of Polio • Spinal Cord Injury • Spinal Muscular Atrophy • Stroke • Acquired Brain Injury noting different types of brain injury require different management • Muscular Dystrophies and Muscular Atrophies.
Reassessment		In this manual, the term 'reassessment' is used to describe a subsequent assessment of a person's aged care needs who is already accessing aged care services. Section 64 of the *Aged Care Act 2024* provides for aged care needs reassessments. A reassessment may be required when an individual's circumstances have changed. In the *Aged Care Act 2024* 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.
Reablement		Wellness and reablement are related concepts, often used together to describe an overall approach to service delivery. Wellness and reablement approaches are based on the idea that, even with frailty, chronical illness or disability, most people want and are able to improve their physical, social, and emotional

Term	Acronym/ abbreviation	Definition
		wellbeing, to live autonomously and as independently as possible. Reablement offers time-limited interventions and emphasises assisting people to maintain, regain, improve confidence and functional capacity and maximise independence and autonomy. It focuses on specific goals and seeks to enable people to live their lives to the fullest.
Residential aged care funding assessment	RAC funding assessment	An assessment a residential aged care funding assessor completes using the AN-ACC assessment tool. Defunct term: AN-ACC assessment.
Residential aged care funding assessor	RAC funding assessor	An aged care assessor who is completing a residential aged care funding assessment using the AN-ACC assessment tool. Defunct term: AN-ACC assessor.
Residential Respite Care (Residential Care – short term)		Residential respite care is short-term care provided in an aged care home. It can be on a planned or emergency basis. Respite gives a carer or care recipient a break from their usual care arrangements. A clinical assessor and approves care recipients to access respite care.
Restorative Care Pathway	RCP	The Restorative Care Pathway, under Support at Home, replaces the Short-Term Restorative Care (STRC) programme. It aims to provide early intervention opportunities to support older people to restore function through coordinated, goal orientated support focusing on multi-disciplinary allied health services. It can be delivered in home or community settings and can be for up to 16 weeks.
Referral Codes Letter		The referral codes letter is also known as the 'Referral codes and List of Providers' Letter On the assessor portal, it is generated via the 'Generate Referral code Letter' button

Term	Acronym/ abbreviation	Definition
Single Assessment System program		The Commonwealth Government funds assessment organisations to administer aged care needs assessments, which include both home support and comprehensive assessments. This term is used to define the assessment program which includes all assessment types.
Single Assessment System workforce		Refers to the aged care assessment workforce from late 2024. This term also includes organisations that deliver Residential Aged Care Funding assessments.
Specialist Aged Care Programs		Means a Government program for delivering funded aged care services that (a) is given effect through one or more agreements or arrangements entered into by the Commonwealth under subsection 247(1) or section 264 of the Act for the program; and (b) meets any other requirements prescribed by the rules. It includes the Multi-Purpose Service Program, Transition Care Program, National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program, and Commonwealth Home Support Program (CHSP).
Specified need		Refers to participants who require ongoing assistive technology funding for the essential maintenance of their assistance dog.
(Commonwealth) Subsidised and non-subsidised aged care services		Commonwealth subsidised aged care programs broadly include those under the Aged Care Act. These services can receive My Aged Care portal referrals and can be service recommendations on the Support Plan. Non-subsidised services are those services and supports that are NOT Commonwealth funded aged care. These services cannot receive referrals through the My Aged Care portal, are NOT listed in the My Aged Care service finder and are noted as general recommendations on the Support Plan.
Support Plan		The Support Plan is an important and ongoing document for the older person that can be updated as an older person's needs change. It details the outcomes of discussions with, and assessments of, the older person, including

Term	Acronym/ abbreviation	Definition
		what the older person would like to improve and achieve (their goals), and agreed actions to be taken. It is a continuous document (i.e. an older person only has one Support Plan).
Support plan review	SPR	A support plan review relates to the effectiveness and appropriateness of the older person's Support Plan. An assessor may set a review date on the Support Plan at the time of the assessment or initiated on an ad-hoc basis. A review may also be requested by an older person or a service provider where there is a change in the older person's needs or circumstances. It may be completed over-the-phone with the older person.
Transition Care Program	TCP	Transition Care provides short-term, goal oriented and therapy-focused care for older Australians after hospital stays either in a home or community setting or in a residential aged care setting.

APPENDIX B – Contact details

Table 60. Contact details

Contact point	Details
Right of Review	A person can request a review to an assessment outcome by writing to: The Secretary Department of Health, Disability and Ageing Attn: Review of Decisions Section GPO Box 9848 ADELAIDE SA 5001
Assessment Operational manager	Please contact your assessment organisation operational manager in the first instance for all queries and/or issues.
Registered supporters	Documentation to request to register a supporter can be sent to My Aged Care by: • Uploading to the My Aged Care Online Account • Uploading it as part of the online registration process on the My Aged Care website • Sending a digital copy via the My Aged Care online form available at: https://www.healthdirect.gov.au/myagedcareupload or • Providing it to an Aged Care Specialist Officer or assessor for face to face help uploading it to My Aged Care. • Posting to: My Aged Care PO Box 1237 Runaway Bay, QLD 4216
Carer Gateway	1800 422 737
My Aged Care contact centre	1800 200 422
My Aged Care Service Provider and Assessor Helpline	1800 836 799 8am to 8pm Monday to Friday or 10am to 2pm Saturday
My Aged Care complaints	A person can make a complaint by: • calling My Aged Care on 1800 200 422 • lodging an online feedback form on the My Aged Care website at myagedcare.gov.au/contact-form • posting their complaint to: My Aged Care Complaints PO Box 1237

Contact point	Details
	Runaway Bay QLD 4216
Services Australia	1800 227 475 (Aged Care Line - consumers)

APPENDIX C – Clinical governance guidance for aged care needs assessment organisations

Guidance purpose

This guidance aims to help aged care assessment organisations to meet their responsibilities for ensuring the quality of needs assessments, through the implementation of effective clinical governance. The sections below are for people within an assessment organisation responsible for developing their clinical governance framework. It describes the importance of good clinical governance, details the elements of an effective clinical governance framework in an aged care needs assessment context and outlines the minimum supports that must be in place to support clinical and non-clinical staff.

This guidance should be considered in conjunction with the resources on clinical governance in the provision of aged care services available on the Aged Care Quality and Safety Commission's website.

What is a clinical governance framework and why is it important for aged care assessment organisations?

Clinical governance is an integrated system of organisational behaviours, policies, procedures, responsibilities, and quality assurance mechanisms that support consistent and high-quality care in organisations across the health, aged care and many social services sectors. A clinical governance framework is a framework that describes an organisation's approach to clinical governance.

Your assessment organisation's clinical governance framework must describe 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.

Good clinical governance supports everyone in your assessment organisation to achieve high quality aged care assessments that deliver accurate and appropriate outcomes for all older people. High quality assessments are defined in the Aged Care Assessment Quality Framework as:

Personal: an assessment is a respectful conversation and is responsive to an older person's individual situation, context, goals and aspirations.

Effective: assessments are undertaken in depth and to completion, ensuring an older person's needs are fully identified and an older person can exercise choice and control in accessing the right services appropriate for them (as available and as eligible).

Connected: the older person understands how and why the assessment process connects to their aged care journey.

Safe: the older person is provided a physically, emotionally and culturally safe assessment where their unique experiences are respected and factored into the way they are assessed for aged care. All assessments are delivered in a safe environment and free from harm.

Importantly, clinical governance must be embedded in your organisational culture. Leaders must foster a culture that supports and promotes consistent, high quality assessments and integrates clinical governance into the broader organisational governance. Your organisation's governing body is accountable for ensuring adequate clinical support is in place for staff, understanding the risks associated with undertaking assessments, monitoring performance, and continuously driving improvement.

How to use this guidance

This guidance outlines the elements that your assessment organisation must include in its clinical governance framework, and details the minimum, practical clinical supports that must be in place for your workforce who may need to exercise clinical judgement or undertake an assessment that is clinical in nature.

Your assessment organisation may develop its clinical governance framework in a format that suits them and include additional elements that are not covered in this guidance. For assessment organisations with an existing clinical governance framework, a review will be required to ensure all elements in this guidance are included.

Elements of a clinical governance framework

At a minimum your assessment organisation's clinical governance framework must demonstrate how it will:

Define **roles and responsibilities** to provide clarity on how clinical governance will operate.

Recruit, **train and accredit staff** to build a highly skilled and qualified assessor workforce.

- Provide **clinical support** to assessors.
- Monitor assessment quality and drive continuous improvement.
- Build relationships to foster innovation and continuous improvement.

The minimum clinical support requirements that sit under each of these elements are detailed in the next section.

Element 1: Define roles and responsibilities to provide clarity on how clinical governance will operate

Table 61. Roles and responsibilities

Clinical support requirement	Implementation
Staff understand the boundaries of their role as a clinical assessor or clinical delegate, and the functions that are not suitable to perform when undertaking those roles. E.g. Clinical assessors who are registered nurses should not dress wounds when undertaking an assessment. Staff understand the boundaries of their role as a non-clinical assessor and non-clinical assessment delegate and	Each staff member is assigned the correct clinical role/s in the My Aged Care Assessor Portal and job position on MAClearning. The organisation's Work, Health and Safety framework outlines procedures that uphold staff safety. Completion of workplace training on the organisation's clinical attendance policy and clinical governance framework. Completion of workplace training on the organisation's clinical attendance policy and clinical governance framework.

Clinical support requirement	Implementation
understand when and how they will need to operate under their organisation's clinical governance throughout the assessment process.	

Element 2: Recruit, train and accredit staff to build a highly skilled and qualified assessor workforce

Table 62. Role and training requirements

Clinical support requirement	Implementation
Every assessor has capability to perform a needs assessment, prior to undertaking an assessment with an older person.	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2025 (and subsequent versions) including mandatory online learning on the MAClearning system and completion of appraisal activities to validate assessor capabilities.
Prior to a clinical assessment delegate approving their first service recommendation, the delegate is competent to approve service recommendations.	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2025 (and subsequent versions) and mandatory online learning on the MAClearning system.
Prior to a triage delegate triaging their first assessment referral, the delegate is competent to undertake triage.	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2025 (and subsequent versions) and mandatory online learning on the MAClearning system
All non-clinical assessors are competent in seeking clinical attendance in the event they trigger clinical questions in the IAT	Completion of training outlined in the My Aged Care Workforce Learning Strategy 2025 (and subsequent versions) and mandatory online learning on the MAClearning system
Relevant staff are qualified to undertake a clinical role.	Staff who are recruited to clinical roles within the assessment organisation meet the qualification requirements outlined in the assessment organisation's contractual agreement and detailed in the My Aged Care Workforce Learning Strategy 2024 (or subsequent versions).

Element 3: Provide clinical support to assessors

Table 63. Clinical support to assessors

Clinical support requirement	Implementation
Provide ongoing support for assessors in the field	Provide ongoing clinical governance support for assessors in the field including providing peer support and advice on emerging and specific issues as well as providing supervision to non-clinical staff during the clinical attendance process and in finalising support

plans. Ongoing support is provided through various communication channels via the assessment organisation's standard operating procedures.

Element 4: Monitor assessment quality and drive continuous improvement

Table 64. Monitoring of assessment quality and continuous improvement

Clinical support requirement	Implementation
Clinical staff are supervised and mentored by a clinically trained Team Leader	Team leaders regularly engage with triage delegates, assessment delegates and assessors in peer review processes
Staff receive regular feedback about the quality of their assessments and the performance of their organisation	Assessment organisations measure and report the extent to which it achieves the Aged Care Quality Standards, and quality goals included in the Aged Care Assessment Quality Framework. The Assessment organisation's leadership team use quality assurance data to drive continuous improvement in clinical governance policies and processes. The Assessment organisation actively participates in any external evaluation or quality assurance processes.

Element 5: Build relationships to foster innovation and continuous improvement

Table 65. Relationship building to foster innovation and continuous improvement

Clinical support requirement	Implementation
Build effective working relationships with local support services	Implement systems and processes to ensure positive communication between service and care providers within the aged and health care systems.
Foster an organisational culture of regular and effective communication that addresses risks and issues and promotes continuous improvement	Assessment organisations hold regular team meetings/teleconferences to address issues arising, share experiences and clinical expertise (including case study discussions)
Assessment Organisation's representatives participate in relevant forums organised by the Department	Assessment organisations must send representatives in person to attend forums for assessment organisations as organised by the Department.

APPENDIX D – Clinical attendance

Questions in the IAT that require clinical attendance

Table 66. IAT questions that require clinical attendance

IAT clinical questions	When these questions will be triggered	Detail
Advanced Medical Assessment section	Answers 'Moderately' or 'Quite a bit' to Q *Impact of health issues on normal activities.*	This question set identifies whether the older person has had recent contact with a GP and/or has regular health checks, has been admitted to hospital in the past 12 months and whether the older person has and/or has had allergies and/or sensitivities such as food, medication and environmental allergies and/or sensitivities. See IAT User Guide: Integrated Assessment Tool user guide (health.gov.au)
Urinary incontinence and Revised Urinary Incontinence Scale (RUIS)	Answers No to '*Is the older person managing urinary incontinence issue?*'	An assessor should use the RUIS to assess urinary incontinence. Urinary incontinence refers to the involuntary loss of bladder control. The severity can vary, including occasional leakage of urine when coughing or sneezing. It would become an issue at the more severe end when an older person often experiences a sudden and strong urge to urinate (urgency) that doesn't allow enough time to reach a toilet. Continence is a sensitive and private issue. The assessor must use clinical judgement to determine the appropriateness of administering the RFIS with the older person at assessment. Urinary incontinence | healthdirect

IAT clinical questions	When these questions will be triggered	Detail
		(PDF) Technical Manual and Instructions: Revised Incontinence and Patient Satisfaction Tools, Version 2 (researchgate.net) (tool on pg. 27)
Bowel incontinence and Revised Faecal Incontinence Scale (RFIS)	Answers 'No' to '*Is the older person managing bowel incontinence issue?*'.	Technical Manual and Instructions for Revised Incontinence and Patient Satisfaction Tools 1 (anzctr.org.au) An assessor should use the RFIS is used to assess faecal incontinence. Continence is a sensitive and private issue. The assessor must use clinical judgement to determine the appropriateness of administering the RFIS with the older person at assessment.
GPCog- Step 2 and extended cognitive assessment	If the older person has answered any of the Qs in GPCog- Step 1 incorrectly.	The GPCog- step 2 and extended cognitive assessment is a screening tool for cognitive impairment. It builds on the questions asked in GPCog- step 1. GPCOG | Home The GPCOG: A New Screening Test for Dementia Designed for General Practice (Step 2 Qs at bottom of the journal article)
Extended Behaviour Assessment	Answers YES to the question. *Are there any reported changes in the older person's personality?*	This question set identifies changes in an older person's behaviour across several behavioural types. See IAT User Guide: Integrated Assessment Tool user guide (health.gov.au)

IAT clinical questions	When these questions will be triggered	Detail
Advanced Psychological Assessment (PHQ-4)	If there is a total score of three or more from the first two PHQ questions (Feeling nervous, anxious or on edge AND not being able to stop or control worrying), additional questions on advanced psychological assessment will be prompted.	This question set identifies the extent to which an older person experiences psychological distress. See IAT User Guide: Integrated Assessment Tool user guide (health.gov.au)
Geriatric Depression Scale (GDS)	Additional question in advanced psychological assessment. Answer 'yes' to *Do you want to complete the Geriatric Depression Scale?*	The GDS is a basic screening measure for depression in older people. Geriatric Depression Scale (stanford.edu)

Older person scenarios — clinical attendance

Meet Clyde

Clyde is 78 years old and needs some extra support so that he can continue to live in his home. He applies for an aged care assessment through My Aged Care. When Clyde is contacted by the assessment organisation, he is asked some preliminary questions (known as triage) before his assessment is scheduled. Clyde has heard some bad stories recently about residential aged care and he is worried that the assessment will result in him moving into an aged care home. Clyde feels nervous when answering the questions at triage and he doesn't fully disclose his health concerns during the conversation.

Clyde is triaged for a home support assessment. A non-clinical assessor is assigned to undertake the assessment, and travels to Clyde's home. During his assessment, Clyde's answers trigger questions that require clinical judgement. The assessor explains to Clyde that there are some questions that will need to be asked with a clinical assessor, who they can call on their tablet.

Clyde agrees and a clinical assessor is video called. Clyde and his assessor explain his situation to the clinical assessor, and the IAT questions that have been triggered. Together, the assessors undertake the whole assessment and record Clyde's needs in the IAT. When the non-clinical assessor gets back to the office, they finalise the assessment, consulting with the clinical assessor to make the recommendations.

Clyde is found eligible for services. The assessor converts the assessment to a comprehensive assessment at the end of the assessment. Clyde's assessment is finalised and is sent to an assessment delegate for approval.

Meet Jane

Jane is 70 years old and lives alone. Jane and her family have spoken about her needing some support to help with home duties. Jane has chronic arthritis and sometimes this can affect her activities. At the time she first speaks to an assessment organisation about her health and abilities (triage), the weather is warm, and Jane is feeling good. Her arthritis is not affecting her day-to-day activities.

Jane is triaged for a home support assessment. A non-clinical assessor is assigned to undertake the assessment, and travels to Jane's home. On the day of the assessment, the weather is cold, and Jane isn't feeling as well as she did at triage. During her assessment, Jane answers a question which triggers a question set that requires clinical judgement. The assessor knows that a clinical assessor is not available to be in attendance during the assessment. The assessor selects 'no' to the declaration and makes a note of the questions that are triggered. The assessor explains that they can only ask certain questions in the assessment today and that some questions will need to be asked with a clinical assessor at a later time. The assessor asks the questions that do not require clinical judgment. The assessment concludes. When the assessor gets back to the office, the assessor speaks to their Team Leader or a clinical assessor about the assessment. At this stage it is determined that the clinical assessor can complete the clinical questions by calling Jane and asking the questions raised during the assessment. The original, non-clinical assessor arranges a time to contact Jane with the clinical assessor to ask the remaining questions. Together they finalise the assessment and although the clinical questions were triggered during the assessment, it is found that Jane's needs can be supported through CHSP services

Meet Alex

Alex loves working with older people and is excited about their new role as a non-clinical aged care needs assessor. Alex arrives at the house of an older person to undertake a home support assessment. Alex is welcomed inside, and notes straight away that the older person's needs seem more complex than what was recorded at triage. Not long into the assessment, a clinical question is triggered that requires clinical judgement. Alex explains to the older person that there are some questions that they will need to ask with the support from a clinical assessor who they can call on Alex's phone. The older person agrees and a clinical assessor is called. Alex explains the situation, including the clinical questions that have been triggered. The clinical assessor considers the questions that have been triggered, Alex's experience as an assessor and the older person's situation. Based on these factors, the clinical assessor advises that it would be best for a clinical assessor to undertake the whole assessment.

Alex concludes the assessment and the older person's assessment is reassigned to a clinical assessor with high priority which occurs on another day.

APPENDIX E – Wellness and reablement

Introduction

My Aged Care has been established to support older people to maximise their independence and enable them to remain living safely in their own homes and communities. The role of the assessor is to work with the older person to develop an individualised Support Plan so the older person can focus on their own strengths and goals to better support their continued independence. This means assessors should not refer the older person for services they can do safely for themselves. The longer an older person avoids reliance on ongoing services, the longer they are likely to maintain their functional independence, giving them more good days doing the things that matter to them most.

Wellness and reablement approaches build on people's strengths and goals to promote greater independence and autonomy, and it starts with the assessment. Wellness and reablement are inclusive approaches that involve assessment, planning and delivery of supports that build on the strengths, capacity, and goals of individuals irrespective of age, capacity, diagnosis or setting. Referring for support that focuses on the individual's goals and recognises the importance of older people's participation is fundamental to aged care.

What is Wellness and reablement?

Wellness and reablement are related concepts, often used together to describe an overall approach to service delivery. They are grounded in the principle that older people, including those with frailty, chronic illness or disability, can maintain or improve their independence, and physical, social and emotional functioning. These approaches support older people to live with purpose, make autonomous choices, and participate in meaningful activities which supports their wellbeing.

By focusing on capacity-building and restoring or maintaining function, wellness and reablement approaches directly contribute to the wellbeing outcomes described in the Aged Care Act and Strengthened Aged Care Quality Standards. These support older people to live safely, independently, and with a sustained sense of meaning and connection in their own homes and communities.

Wellness

Wellness is a philosophy that informs how providers should work with participants by building on their strengths, abilities and goals to promote greater independence and quality of life. A wellness approach avoids 'doing for' when 'doing with' can support a participant to undertake an activity with less assistance, acknowledging the abilities of the participant and building on their strengths and skills. A wellness approach also aims to empower participants to take charge of, and participate in, informed decision-making about the care and services they receive. It's about listening to what the participant wants to do, looking at what they can do, and focusing on regaining or retaining their level of function so that they can continue to manage their day-to-day life.

Reablement

Reablement offers time-limited interventions that focus on achieving a participant's specific goal or desired outcome. It involves maintaining or regaining skills, improving functional capacity, improving confidence and enhancing capability so a participant can resume everyday activities. Reablement services apply a wellness approach and aim to get a client 'back on their feet,' and able to resume previous activities either without needing ongoing service delivery or with a reduced need for services. Service providers should identify opportunities for reablement as part of their ongoing support of participants.

Why wellness and reablement is important

Emerging research has demonstrated the benefits of focussing on older people's independence. Traditional models of service delivery that focus on what an older person can't do rather than what they can, leads to an over-reliance on services by older people, which has been linked with accelerated functional decline.

Understanding the ageing journey – the life curve

Research suggests the largest influencer in age-related decline is not genetics, but rather lifestyle choices. People who continue to do things for themselves tend to remain independent and live better, longer.

Professor Peter Gore of the Institute of Aging at Newcastle University in the United Kingdom has developed a framework to understand the age-related decline. The framework, called the LifeCurve™, looks at the impact of maintaining independence on quality of life and the rate of age-related functional decline. It illustrates that the sooner someone stops performing certain tasks for themselves, the faster they tend to lose their functional ability. The aim is to assist people to perform these daily tasks independently for as long as possible, to maximise independence and autonomy. Retaining physical ability helps people to continue doing the things they enjoy for longer.

The LifeCurve™ is shown at Figure 12. The vertical axis lists activities of daily living that older people generally lose over time, in the order in which they tend to be lost, from top to bottom, with the horizontal axis representing elapsed time. The timeframe for this decline is variable and can be influenced by behaviour and interventions. For example, difficulty cutting one's toenails is typically seen as an early indicator that intervention may be needed. The graph shows two trajectories: a sub-optimal life curve with a fast early decline; and an optimal life curve in which the early decline is slowed down to give people more good days before losing the ability to undertake activities like walking, shopping and personal care.

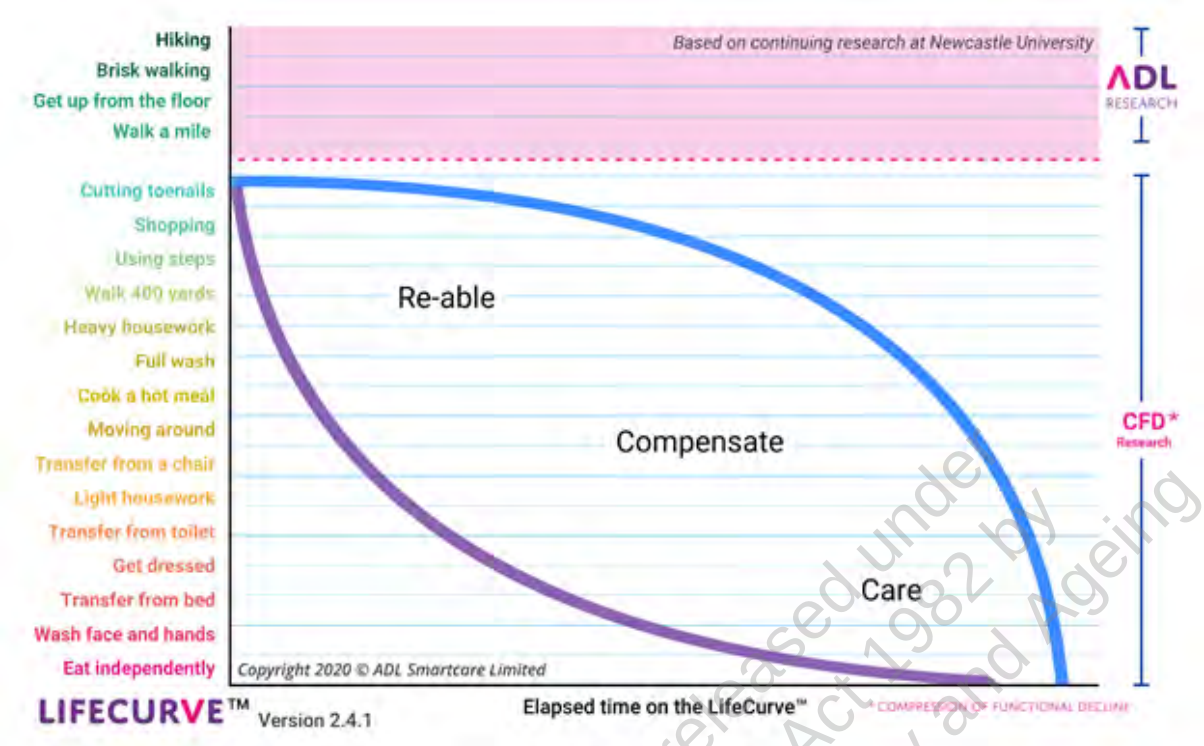

Figure 12 – LifeCurve™

The LiveUp website enables Australians over 65 years of age to check their health and find personalised suggestions for products and services that promote healthy ageing. LiveUp can suggest low-cost assistive products and equipment to help people with everyday living, as well as personalised exercises and services, to help them or a loved one with age-related wellbeing.

At the LiveUp website anyone can download the free LifeCurve™ that can track a person's health, giving them easy to understand long term advice tailored to their needs. To learn more about LiveUp, go to www.liveup.org.au or call 1800 951 971.

Benefits of a wellness and reablement approach

Older people are not the only ones who benefit from wellness and reablement. Evidence suggests there are also significant benefits to assessment organisations, service providers, families and carers, and the broader community.

Benefits for older people

Implementing a wellness and reablement approach at the earliest opportunity (with a focus on older person goals to maintain or regain functional capacity and social connectedness) can have significant long-term benefits for older people including:

- older people appreciate being asked what is important to them, and to be included in decision-making
- improved sense of purpose, autonomy and self-worth
- improved physical and emotional health and wellbeing
- reduction in service delivery needs

- increased ability to remain living independently and safely in their own homes for longer
- greater quality of life and retention of pride and dignity
- improved connection with community; and
- reduced strain on family and carer relationships.

Benefits for aged care assessment organisations

Reablement focused assessment has flow on benefits for aged care organisations as they can better utilise support workers to focus on more complicated tasks that their older people can't perform for themselves, resulting in more meaningful and fulfilling work. Importantly, it enables providers to broaden their older person base by offering more short-term support by freeing up longer term service provision. All of which better aligns to aged care reform initiatives and improving the ability to assessment and provider organisations to respond to changes in aged care policy.

Implementing wellness and reablement provides significant benefits for assessors and their older people including:

- reablement focussed (active) assessment better demonstrates need. This benefit extends to older people with poor reablement prospects, as active assessment better identifies if ongoing services are needed, or if short-term reablement support will help the older person get back to previous levels of independence
- reablement focussed assessment provides a more holistic approach to assessment
- greater job satisfaction by actively helping older people to identify goals and become more independent; and
- improved business reputation based on providing person-centred, holistic assessments that focus on individual older person goals, needs and preferences.

Benefits for families and carers

Wellness and reablement approaches can have significant benefits for family members and carers, including:

- opportunities to be involved in supporting their loved one to meet their goals
- peace of mind in knowing their loved one is retaining or regaining their independence, improving their wellbeing and quality of life
- reduced worry and concern over their loved ones along with reduced strain and pressure due to a decrease in caring requirements.

Older person scenarios — Applying a wellness and reablement approach

HARRY is a 70-year-old man who lives alone. After contacting My Aged Care, a face-to-face home support assessment was undertaken which identified Harry needed some assistance with clothes-washing and meals. The assessor applied a wellness and reablement approach in the assessment, asking Harry to show how he performed tasks around the home, observing what he could do for himself and asking him what goals he wanted to achieve.

At first, Harry didn't know what to say. He thought he was too old to set new goals, but indicated he was open to doing the cooking. Harry said he lacked confidence and skills as his wife, who recently passed away, had always done most of the cooking. With this information, the assessor referred Harry for support with planning his grocery shopping and meal preparation. With this support, Harry could work out what he wanted to cook, plan his shopping to obtain the necessary ingredients, and then helped his support worker prepare the meals while receiving basic cooking instructions.

Learning these skills built Harry's confidence to manage his shopping and cook his own meals, increasing his independence and quality of life.

During the assessment, the assessor also encouraged Harry by helping him identify task simplification strategies to do the laundry with some support. Instead of referring for domestic assistance three times a week, the assessor advised Harry to wash and hang his clothes using a trolley and an easy-to-reach drying rack inside, instead referring him for once-a-week support to help him hang out heavier washing, like sheets and towels.

ELSA is a 72-year woman with osteoarthritis who has been receiving domestic assistance under the CHSP for two hours a week to provide assistance with general housework and laundry. Elsa required no other assistance.

During a support plan review, the non-clinical assessor applied a wellness and reablement approach to Elsa's continuing needs, asking Elsa to demonstrate how she completed light household chores such as dusting, wiping over surfaces, washing the dishes and using a lightweight carpet sweeper.

Applying a reablement approach, over a two-month period instead of 'doing for', Elsa was encouraged to undertake some of these tasks by herself, whilst the support worker completed more difficult tasks, such as vacuuming and mopping.

Elsa still requires ongoing support; however, she is now more involved and independent, has increased activity levels, and feels more satisfied about continuing to live at home.

Principles of wellness and reablement

Wellness and reablement describe an overall approach to service delivery.

Employment of wellness and reablement approaches in aged care organisations promotes client wellbeing, independence, function, and management of activities of daily living.

In line with the Statement of Rights, ways to apply wellness and reablement approaches include:

- **Promote independence** – people value their independence, loss of independence can have a devastating effect, particularly for older people who may find it more difficult to regain.
- **Identify older person's goals and motivation** – a person's independence requires more than just services to help them remain in their home and maintain their current capacity. Service delivery should focus on supporting the older person to actively work towards their goals and improved independence wherever possible.
- **Consider physical and psychosocial needs** – independence is not limited to physical function, it includes both social and psychological function. Support should be tailored to the individual and aim to improve their physical, social and emotional wellbeing.
- **Encourage participation of older people** – being an active participant, rather than a passive recipient of services, is an important of being physically and emotionally healthy. Service delivery should focus on assisting a person to complete tasks, not taking over tasks that a person can do for themselves.
- **Regular assessment** – older person assessment should be ongoing, not one-off. It should focus on progress towards older person goals and consider the support and duration of services required to meet these goals.
- **Focus on strengths** - the focus should be on what a person can do, rather than what they can't. Wherever possible, services should aim to retain, regain, or learn skills rather than creating dependencies.
- **Support older people to reach their potential** – help older people to maintain and extend their activities in line with their capabilities.
- **Individualise support** – service delivery should be individualised and suited to the goals, aspirations and needs of the individual.
- **Regular review –** a person's assessment should be ongoing, not one-off. It should focus on progress towards goals and consider the support and duration of services required to meet these goals.

HELEN is a 78-year woman with osteoarthritis. Lately, Helen has had difficulty performing household cleaning duties and doing her laundry. At assessment, the assessor undertook a reablement-focused (active) assessment to better identify Helen's needs.

By asking Helen to show the assessor how she did her housework (active assessment), the assessor identified lighter tasks that Helen could still complete, but certain tasks impacted her arthritis. During the assessment, the assessor asked Helen what she enjoys and the goals she would like to achieve. Helen identifies she used to enjoy keeping her home clean and tidy but is feeling lonely because she worries visitors may think she isn't coping around the house as well as she used to.

In working with Helen to develop a Support Plan, the assessor focusses on Helen's strengths and the things she wants to regain/maintain. As a result of the active assessment, the Support Plan refers Helen for short-term reablement support over a two-month period where Helen does lighter housework while the support worker completes tasks that provoke Helen's arthritis, such as vacuuming and mopping.

Although Helen requires ongoing support with more difficult domestic duties, she has improved her functional capacity and feels more like herself. By adopting a strength-based approach to assessment and service delivery, focusing on 'doing with' not 'doing for', Helen is able to maintain some physical activity and by regaining some independence she is feeling more fulfilled and capable. Helen has begun engaging with her friends again which has improved her social connectedness.

Time-limited support

Wellness and reablement approaches often involve time-limited services. Time-limited care aims to address an older person's specific barriers to independence and support them getting back to doing things for themselves. This involves a targeted timeframe, developed with the older person, for achieving their goals.

Understanding what a good day looks like for an older person and how it relates to their individual goals and outcomes is important for determining short-term support needs. This could be maintaining a level of activity or independence or working towards regaining it. Time-limited reablement services tend to be delivered within a 12-week period with the aim to wrap up services when the older person has met their goal or specific outcome. Time-limited reablement under the CHSP can be delivered by all service types (with the exception of Sector Support and Development).

Time-limited reablement may involve restorative care services where the client has the potential to make a functional gain.

Other time-limited support could include:

- training in a new skill or actively working to regain or maintain an existing skill

- modification to a person's home environment; or
- having access to assistive technology.

Wellness and reablement obligations and supports

As part of applying a wellness and reablement approach assessment organisations should:

- ensure that assessment referrals are targeted towards assisting older people to achieve their agreed realistic goals as outlined in the Support Plan
- apply a 'doing with' instead of 'doing for' approach where possible, offer time limited interventions
- monitor changes in older person's needs and regularly review Support Plans
- comply with wellness and reablement reporting requirements; and
- have an implementation plan outlining their organisation's approach to embedding wellness and reablement.

The department has developed online resources to help service providers embed wellness and reablement approaches into their practices and service delivery.

Other resources

Wellness and reablement resources page

Living well at home: CHSP Good Practice Guide provides practical guidance in how to adopt a wellness and reablement approach into service delivery.

Older person scenario – Supporting greater independence[11]

ADELINA is a 77-year-old woman who had a stroke which affected her left side. Her speech was unaffected, but her movement was restricted. She has little function in her left arm - her left leg is slightly affected, requiring her to walk with the assistance of a stick.

Adelina felt that she was unable to do very much for herself. She really wanted to be able to make her own cup of tea, however because of the lack of function in her left arm she felt she was dependent on carers and unable to make a cup of tea between carer visits unless a friend or neighbour came by. Adelina had become resigned that this was how her life would be. She was dispirited and resistant to her son's suggestion that she might do a bit more for herself.

However, at the request of her son, Adelina's Support Plan was reviewed by the assessor who recommended a referral to an occupational therapist. An occupational therapist was engaged under the CHSP who suggested she could be assisted to learn to use the microwave oven, and a kettle fitted onto a tipper so she could make her own tea.

For a number of weeks, Adelina was supported to build up her confidence in her ability to use the microwave and the kettle. After a few months Adelina was able to make meals for herself, her own cup of tea and is living a more independent life. As a result, Adelina said she is feeling more hopeful and has started to invite friends over for a meal.

[11] Wellness Approach to Community Home Care Information Booklet July 2008 produced by the Western Australian Department of Health

Cont. Adelina's son has been delighted to see his mother's renewed sense of self and independence.

Strategies to assist embedding wellness and reablement

Experience of organisations that have successfully embedded a wellness and reablement approach suggests that there are a number of key drivers for success. These include:

- a whole-of-organisation approach, including commitment from both management and staff
- reflecting wellness and reablement in organisational policy and procedures, especially in recruitment, employment, orientation, induction practices, position descriptions, and performance reviews.
- providing and encouraging staff training and education program
- changing the mindset for management, staff, volunteers, older people and their families and carers
- taking time to work with staff to ensure they understand the benefits and reasons for applying wellness and reablement approaches.
- understanding your organisation's maturity and readiness in terms of wellness and reablement is the first step to embedding the change; and
- ensuring communication materials need to reflect the wellness and reablement approach to assist with setting older person and staff expectations.

Older person scenarios — short-term wellness and reablement, and restorative interventions

DAVID is an 81-year-old man who was referred to My Aged Care following a fall he had two weeks prior. Although he sustained no specific injuries, David was quite shaken following the fall, and now lacked confidence to shower himself independently.

David was referred for an assessment which identified that David was previously independent and was motivated to regain autonomy. The assessor also identified that David was still independent in many daily activities, but was struggling with his personal care.

Based on the assessment, a Support Plan was developed with David which identified his goal of being able to maintain his personal care independently. The support plan provided information on David's strengths and abilities, as well as his areas of difficulty and recommendations to achieve his goals. This included a referral to a CHSP service provider for an occupational therapy assessment, and the delivery of time-limited personal care services.

The occupational therapist used the support plan to work with David and his personal carer to achieve his goals. Initially, personal care services were provided to David three times a week to assist him with showering. Over a four-week period, the CHSP service provider worked with David to develop specific strategies such as how to step in and out of the shower safely, to help him to build his capacity and regain confidence in showering. After four weeks of service David was confident to shower independently again, and the services were withdrawn.

BILL is a 75 year old man who lives at home with his wife Irene. Bill had not previously received any aged care services since he and Irene had always enjoyed good health. Recently Bill had an accident which had resulted in him spending time in hospital. Although Bill recovered well from his accident, it had left him feeling anxious about leaving the house. Also, his hospital stay and inactivity had reduced his physical fitness, preventing Bill from doing as much around the house and garden as he had done before.

Bill's wife Irene contacted My Aged Care and Bill was referred for an assessment. Bill's assessor worked with him to identify the things that he liked to do and what he no longer felt comfortable doing. A Support Plan was developed with Bill, which included some time-limited interventions with a restorative care focus, including referral:

*to physiotherapy or exercise physiologist (to develop a suitable strength, balance and endurance program)

*to an occupational therapist (to identify energy conservation strategies and/or suitable equipment to promote functional independence)

*for some time-limited home maintenance and domestic assistance.

Following this time-limited support, Bill now feels more confident living at home and has regained much of his former capacity to undertake the home maintenance and domestic chores that he used to do. Applying this short-term restorative care intervention approach enabled Bill to regain his strength and confidence and prevented a possible longer-term dependence on ongoing support services.

Assessment and support planning

The role of the assessor is to work with the older person to identify their needs and concerns, as well as their goals and aspirations. As part of the IAT, the assessment must include the older person's:

- current level of support (formal and informal) and engagement
- carer availability and sustainability
- health concerns and priorities
- functional status
- psychosocial and psychological concerns, and
- home and personal safety considerations.

The assessor then works with the older person to develop a Support Plan which focuses the support needed to assist them to achieve their goals. In developing a Support Plan with an older person, the assessor will:

- Focus on what an older person can do and discuss what they need to complete more difficult tasks, such as breaking down into simpler components.
- Discuss strategies to manage day-to-day tasks (e.g. transport planning to meet goals around the use of public transport to maintain usual activities).
- Explore the older person's opportunity for supporting independence through wellness and reablement approaches (e.g. can the older person benefit from time-limited support and/or the use of specific aids and equipment or home modifications such as installing shower rails to build confidence and independence).

Developing a Support Plan with the older person helps to ensure that it accurately reflects the older person's needs and achievable goals and discusses with the older person the role

they will need to play to achieve them how they feel about this (motivation). This will increase the likelihood that the older person will be motivated to work towards the goals they have identified, including supporting their independence through wellness and reablement approaches.

In some circumstances, where the assessment has identified that a short-term intervention is appropriate, the assessment organisation is required take on a coordination role to ensure that all referrals in the Support Plan are linked to one or more service providers and that they will all be delivered within an agreed time frame.

For older people receiving wellness and reablement support, assessors should include review dates on the older person's Support Plan to monitor the older person's progress towards their goals and desired outcomes. The need for ongoing, or an adjustment in services will also be assessed. In these circumstances, CHSP service providers should provide time limited services in line with your Support Plan.

Older person scenario – wellness and reablement-focused assessment with support planning

CECELIA is an 81-year-old woman who lives alone. Before experiencing a stroke earlier in the year, Cecelia had been actively involved in her church and local community. However, following the stroke, Cecelia stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she had also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening.

Cecelia was referred to My Aged Care by her doctor and following the initial registration process and triage, a face-to-face assessment was organised. Cecelia's assessment helped to identify her strengths and capabilities as well as her needs. The resulting support plan was centred around Cecelia's own goals which included getting stronger, resuming her church activities, doing more about the house and getting back out in the garden. Cecelia's support plan included:

* referral to an allied health professional to assist with her goal of getting stronger,
* referral to a CHSP domestic assistance service provider to provide assistance with the more difficult household chores and to help Cecelia to identify which chores she could still manage to do on her own,
* assistance to identify and make contact with a pastoral care team member to discuss her continued interest in participating in church activities, and
* referral to a home maintenance service for discussion and planning to convert her garden to be safer and more accessible, and lower maintenance.

After mastering basic strength and balance exercises through a home exercise program designed by the allied health professional, Cecelia was eventually able to walk unaided inside her home. A more confident Cecelia then arranged a 'buddy' to drive her to and from church activities. At the same time, the CHSP domestic assistance service provider worked with Cecelia to assist her to take on some of the easier housekeeping chores enabling her to remain more active and independent. Cecelia was also delighted to find that the new raised garden beds enabled her to access and maintain her garden more safely without affecting her enjoyment of the garden.

APPENDIX F – Aged care assessment workforce minimum qualifications

Assessment organisations must ensure their workforce has the appropriate training, skills and credentials to provide aged care needs assessments and related services. The below table lists the workforce credentials requirements for key roles within Assessment organisations referenced in Chapter 2. Training requirements for each role are detailed in the Workforce Learning Strategy.

Table 67. Aged care assessment workforce minimum qualifications

Role	Minimum qualification requirements
Triage Delegate	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of or eligible to be part of a relevant professional association. • at least one years' Aged Care Needs Assessment experience preferred. **Additional qualifications recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • Aboriginal and Torres Strait Islander Health Practitioners with a Diploma of Aboriginal and/or Torres Strait Isander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia • Allied Health Assistants with a Diploma or above qualification in Allied Health Assistance and holds or is eligible for a Practising Member (certified) membership with the Allied Health Assistant's National Association • Exceptions to the above qualifications may apply in certain circumstances, including (but not limited to) when the role is located in a remote area. Where an exception applies, a business case must be supplied to the Department for consideration. .

Role	Minimum qualification requirements
Clinical Assessment Delegate	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of or eligible to be part of a relevant professional association. • At least one years' Aged Care Needs Assessment experience preferred. **Additional qualifications recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • Aboriginal and Torres Strait Islander Health Practitioners with a Diploma of Aboriginal and/or Torres Strait Isander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. • Allied Health Assistants with a Diploma or above qualification in Allied Health Assistance and holds or is eligible for a Practising Member (certified) membership with the Allied Health Assistant's National Association.
Non-Clinical Assessment Delegate	• No minimum qualification. Current work experience in aged care or Aged Care Needs Assessment preferred. • At least one years' Aged Care Needs Assessment experience preferred.

Role	Minimum qualification requirements
Clinical Aged Care Needs Assessor	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of or eligible to be part of a relevant professional association. • Minimum of one year demonstrated experience in Australia or overseas directly delivering services in aged care settings and/or to aged persons (such as geriatric evaluation, rehabilitation, palliative care, community nursing), including to people living with dementia. Note: An Enrolled Nurse may be considered for a clinical assessor role *only if they are under direct or indirect Registered Nurse supervision within the same organisation.* A business case is required. Aboriginal and Torres Strait Islander Health Practitioners with a Cert IV in Aboriginal and Torres Strait Islander Primary Health Care Practice may be considered for a clinical aged care needs assessor provided they are operating within their scope of practice. A business case is required for mainstream Single Assessment System organisations. **Additional qualifications recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • A Cert IV or above in Aboriginal and/or Torres Strait Islander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. • a Cert IV or above in Allied Health Assistance and holds or is eligible for a Practicing Member (Certified) class of membership with the Allied Health Assistants' National Association
Non-Clinical Aged Care Needs Assessor	• No minimum qualification. Previous knowledge or work experience in the aged care system preferred.

Role	Minimum qualification requirements
Aged Care Needs Assessment Team Leaders	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the AHPRA or part of or eligible to be part of a relevant professional association. • At least one years' experience as a Clinical Aged Care Needs Assessor preferred. **Additional qualifications recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • A Cert IV or above in Aboriginal and Torres Strait Islander Primary Health Care Practice. • an Enrolled Nurse under the supervision of a Registered Nurse may be considered for the Team Leader role.
Workplace Trainer	• At least one years' experience as an Aged Care Needs Assessor and as listed in the My Aged Care Workforce Learning Strategy. and/or • Training qualifications (such as a Cert IV or higher in training and assessment) or Bachelor degree in education, or higher.
Administrators (e.g. organisational and/or outlet administrators)	• At least three months' experience in aged care or Aged Care Needs Assessment preferred.
Contract Manager	Nil specified
Assessment Organisation Operational Manager	Nil specified
Administration Officer	Nil specified
Delegate Support	Nil specified

*Suitable tertiary qualifications are those that:

- Are relevant to health and/or aged care, and
- Have a practical component (i.e. clinical practice/practicum placement hours), and
- Include subjects that assess function/mobility, such as anatomy physiology, and/or health and wellbeing

APPENDIX G – AT-HM terms

Table 68. AT-HM terms and definitions

Term	Definition
Tier indicator	Item which aligns with an older person's function and home environment.
Mild/Minimal	Minor, infrequent and no significant impact.
Moderate	Medium, regular and has some impact.
Significant:	Considerable, frequent and complex with serious impact.
Progressive condition:	A medical condition that worsens over time, resulting in a range of limitations in function which can affect quality of life, daily living and community activities. (The 13 conditions listed below are all eligible AT-HM progressive conditions under SaH). These conditions include: • Cerebral Palsy • Epilepsy • Huntington's Disease • Motor Neurone Disease (MND) noting different phenotypes require different management • Multiple Sclerosis (MS) • Parkinson's Disease • Late effects of Polio • Spinal Cord Injury • Spinal Muscular Atrophy • Stroke • Acquired Brain Injury noting different types of brain injury require different management • Muscular Dystrophies and Muscular Atrophies.

APPENDIX H – Case studies- individuals experiencing homelessness or who are at risk of homelessness

The following case studies have been drawn from the department's 'Definition for Assessing Eligibility for Australian Government Funded Aged Care Services: Individuals Experiencing Homelessness or At Risk of Homelessness' policy. Triage Delegates may wish to use the case studies to assist in building their understanding of the definitions and whether they apply to an older person has made an application for an aged care needs assessment.

Case Study 1: Meets Eligibility Requirements

Greg, aged 52, has a history of living in abandoned houses, hotels, and squatting in empty homes. He has been residing in a boarding house for the past three years, where his living conditions have been relatively stable. However, Greg's mobility has gradually deteriorated, leading to multiple falls and subsequent hospital admission for fractures. Additionally, Greg suffers from post-traumatic stress disorder (PTSD) due to past trauma. Greg faces significant challenges in his daily life. He struggles with basic activities such as showering and preparing nutritious meals. He relies on a walker to move around the boarding house but is afraid to leave his room because the boarding house lacks the necessary aids to ensure his safety. Greg has no assets and survives on a small pension. Although he does not have a formal disability, his difficulties with daily living activities prevent him from living independently.

Greg meets the criteria for accessing Australian Government aged care services because Greg:

a. Is aged 50 years or older: Greg is 52 years old.
b. Has prematurely aged and requires services for their aged care needs: Greg's deteriorating mobility, multiple falls and PTSD indicate that he has prematurely aged and requires aged care services.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Greg has been living in a boarding house.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Greg has a history of unstable living conditions, including living in abandoned houses, hostels, and squatting in empty homes.
    - Stays in accommodation that falls below minimum community standards: the boarding house lacks necessary aids to ensure his safety, which may fall below minimum community standards.
d. Does not have the means to change their living arrangements: Greg has no assets and survives on a small pension, indicating he lacks the financial means to change his living arrangements.

Case Study 2: Meets Eligibility Requirements

Ann, aged 59, receives a small pension and has no assets. She suffers from chronic pain and declining mobility, which have led to several falls in the past six months. Struggling to pay rent, Ann was recently evicted from her private rental home due to rent arrears. Following the eviction, she moved in with a family member and is currently sleeping in the living room. Ann requires assistance with daily activities, including meal preparation and personal care, due to her health conditions.

Ann meets the criteria for accessing Australian Government aged care services because Ann:

a. Is aged 50 years or older: Ann is 59 years old.
b. Has prematurely aged and requires services for their aged care needs: Ann's chronic pain, declining mobility, and frequent falls indicate that she has prematurely aged and requires aged care services.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Ann is currently living with a family member.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Ann was recently evicted from her private rental home and is now sleeping in the living room of a family member's home, which can be considered a temporary or insecure living arrangement.
    - Stays in accommodation that falls below minimum community standards: Sleeping in the living room of a family member's home may fall below the minimum community standards for adequate housing.
d. Does not have the means to change their living arrangements: Ann has no assets and receives a small pension, indicating she lacks the financial means to change her living arrangements.

Case Study 3: Meets Eligibility Requirements

John, aged 60, has a history of living in shelter accommodation and his care, and is currently residing in a caravan in a remote location. He suffers from diabetes and related complication, requiring daily insulin. However, John struggles to manage his medication, leading to multiple hospital admissions. His living conditions have worsened and his health, as exposure to cold weather and lack of a heating system have negatively impacted him. John has no financial resources and is unable to work due to his chronic health conditions.

John meets the criteria for accessing Australian Government aged care services because John:

a. Is aged 50 or older: John is 60 years old.
b. Has prematurely aged and requires services for their aged care needs: John's diabetes, related complications and difficulty managing his medication indicate that he has prematurely aged and requires aged care services.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: John's caravan in a remote location, lacking a heating system, can be considered unfit housing with substandard conditions.
    - Has no security of tenure or moves between various forms or temporary or medium-term shelter: John's has a history of living in shelter accommodation and his care, and is now in a caravan, which can be considered a temporary or insecure living arrangement.

- Stays in accommodation that falls below minimum community standards: The caravan's lack of heating and remote location may fall below minimum community standards for adequate housing.

d. Does not have the means to change their living arrangements: John has no financial resources and is unable to work due to chronic health conditions, indicating he lacks the means to change his living arrangements.

Case Study 4: Does Not Meet the Eligibility Criteria

Peter, aged 53, has a disability and has always lived with his parents in their residential home. Recently, Peter's father has passed away, and his mother's health deteriorated leading her to move permanently to a residential aged care facility. Peter has been approved for a NDIS plan, which provides resources and funding for him to move to a NDIS group home with other participants. Although Peter did not own a home and had never lived outside the family home, he now has access to resources that allow him to move permanently into a stable and adequate home, where he can receive more appropriate support.

Peter does not meet the criteria for accessing Australian Government aged care services because Peter:

a. Is aged 50 or older: Peter is 53 years old.
b. Has permanently aged and requires services for their aged care needs: Peter has a disability, but the information does not indicate that he has prematurely aged or requires aged care services specifically related to ageing.
c. Has the following living arrangements:

- Lacks any adequate roof over their head: Not applicable, as Peter has access to a stable and adequate home through the NDIS plan.
- Has no security of tenure or moves between various forms of temporary or medium-term shelter: Not applicable, as Peter has a permanent arrangement in the NDIS group home.
- Stays in accommodation that falls below minimum community standards: Not applicable, as the NDIS group home is described as table and adequate.
-

d. Does not have the means to change their living arrangements: Not applicable, as Peter has access to resources and funding through the NDIS plan to move to a stable home.

Case Study 5: Does Not Meet the Eligibility Criteria

Maragret (Maggie), aged 56, has been living in a boarding house for almost two years. Recently, she experienced a medical episode and was admitted to hospital. After receiving treatment, Maggie has now recovered and is now medically stable with no residual care needs. Maggie has no assets and receives a small pension. Maggie also works on a casual basis in the local café and grocery shop.

Maggie does not meet the criteria for accessing Australian Government aged care services because Maggie:

a. Is aged 50 years or older: Maggie is 56 years old.

b. Has prematurely aged and requires services for their aged care needs: Maggie has recovered from her medical episode and is now medically stable with no residual care needs, indicating she does not require aged care services.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Maggie is living in a boarding house.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Meggie's boarding house could be considered a transitional housing arrangement, which may may fit this criterion.
    - Stays in accommodation that falls below minimum community standards: The boarding house could be considered accommodation that falls below minimum community standards.
d. Does not have the means to change their living arrangements: Maggie has no assets and receives a small pension, but she also works causally which may provide some means to change her living arrangements.

Given these points, Maggie does not seem to meet the criteria outlined in the definition for accessing aged care services, primarily because she has no ongoing aged care needs.

Case Study 6: Does Not Meet the Eligibility Criteria

Pedro, aged 59, has been living alone in a self-contained house in a caravan park for nearly seven years. Three years ago, Pedro was diagnosed with stage III colon cancer. He underwent surgery and chemotherapy, and after a period of recovery, he believed he was in remission. Unfortunately, Pedro's cancer returned, and he was diagnosed with stage IV colon cancer. He is now in the palliative stage. Despite his diagnosis. Pedro remains fully independent and manages his pain with medication. Pedro enjoys living in the caravan park community and receives regular visits from his family. Pedro does not have any care needs, lives independently in stable housing that meets housing standards, and is able to perform daily activities without assistance.

Pedro does not meet the criteria for accessing Australian Government aged care services because Pedro:

a. Is aged 50 or older: Pedro is 59 years old.
b. Has prematurely aged and requires services for their aged care needs: Although Pedro has stage IV colon cancer, he remains fully independent and does not have any care needs related to ageing.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Pedro lives in a self-contained house in a caravan park.
    - Has no security of tenure or moves between various forms of temporary of medium-term shelter: Not applicable, as Pedro has been living in stable housing for nearly seven years.
    - Staying in accommodation that falls below minimum community standards: Not applicable, as Pedro's housing meets standards, and he lives independently.
d. Does not have the means to change their living arrangements: This is not explicitly mentioned in Pedro's case, but his current living situation is stable and adequate.

Pedro does not seem to meet the criteria outlined in the definition for accessing aged care services, primarily because he does not have any aged care needs and lives independently in stable housing.

Case Study 7: Does Not Meet the Eligibility Criteria

Louise is 61 years of aged. Louise's husband passed away three years ago and now lives by herself in a two-story house in a small community. Louise was in fairly good health condition but recently had an accident and was admitted to hospital where she underwent surgery. After a long recovery period, and still requiring visits to the physio, Louise is back home. Louise complained that she is not able to access the second floor where she has her bedroom. Louise was a teacher before she had kinds and left her job to dedicate her time to the family. Louise is the owner of the house where she lives and funds available, but she is struggling to live in the current house due to residual needs from the accident.

Louise does not meet the criteria for accessing Australian Government aged care services because Louise:

a. Is aged 50 years or older: Louise is 61 years old.
b. Has prematurely aged and requires services for their aged care needs: Louise has residual needs from her accident, but this does not necessarily indicate premature ageing or a need for aged care services specifically related to ageing.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Louise lives in a two-story house.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Not applicable, as Louise owns her house.
    - Staying in accommodation that falls below minimum community standards: Not applicable, as her house does not fall below minimum community standards.
d. Does not have the means to change their living arrangements: Louise has assets and funds available, indicating she has the means to make necessary changes to her living arrangements.

Louise does not mee the criteria outlined in the definition for accessing aged care services.

Case Study 8: Does Not Meet the Eligibility Criteria

David is 58 years of age and lives permanently in a granny flat on his parent's property. David has a range of medical conditions, including severe obesity, type 2 diabetes and diabetic neuropathy, among others. David has had multiple hospital admissions in previous years and is currently in hospital following a five-week admission for the management of fluid retention. However, the hospital has now found David is medically stable for discharge. David has no assets and no other source of income apart from the Disability Support Pension.

David does not meet the criteria for accessing Australian Government aged care services because David:

a. Is aged 50 or older: David is 58 years old.
b. Has prematurely aged and requires services for their aged care needs: David has multiple medical conditions, but the information does not indicate that he has prematurely aged or requires aged care services specifically related to ageing. David's conditions appear to be medical rather than age-related.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as David has access to a stable and adequate home living with his parents.

- Has no security of tenure or moves between various forms of temporary or medium-term shelter: Not applicable, as David has been living permanently with his parents.
- Stays in accommodation that falls below minimum community standards: There is no indication that David's accommodation falls below minimum standards.

d. Does not have the means to change their living arrangements: David has no assets and receives a small pension, indicating he lacks the financial means to change his living arrangements.

David does not meet the criteria outlined in the definition for accessing aged care services, primarily because David does not have any care needs related to ageing, nor has he prematurely aged due to experiencing homelessness.

Australian Government
Department of Health, Disability and Ageing

Aged Care Assessment Manual

Version 8.1

Published 1 November 2025

IMPORTANT

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

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

This manual replaces the *Aged Care Act 2024 Guide for the Single Assessment System* which has been decommissioned. This guide should not be referenced as it contains information that has since been updated.

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

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

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Document purpose

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

In addition to the guidance in this manual, assessors are expected to also use the Aged Care Assessment Quality Framework to deliver a high-quality assessment experience and service for every older person. All assessors, delegates and team leaders are also required to complete the mandatory training outlined in the My Aged Care Workforce Learning Strategy 2025 (and subsequent versions).

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

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

Key sources of information to complement this manual include:

- IAT User Guide
- Aged Care Assessment Quality Framework
- Aged Care Act 2024
- Aged Care Rules 2025
- My Aged Care website
- Fact sheets for Assessors
- My Aged Care Assessor Portal resources
- My Aged Care Workforce Learning Strategy
- Support at Home Program Manual for 1 November 2025
- Commonwealth Home Support Program (CHSP) Manual 2025-2027
- Multi-Purpose Service Program (MPSP) Fact Sheets
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) Manual
- Aboriginal and Torres Strait Islander Aged Care Framework
- Support at Home Assistive Technology and Home Modifications (AT-HM) scheme Fact Sheet
- Transition Care Program (TCP) Guidelines
- Support at Home Pricing Resources

Terminology

Throughout this document:

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

This symbol displays throughout the document and denotes significant change in information and the assessment process with the introduction of the *Act*.

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

Document Structure

Chapter	What you'll find in this chapter	Key Changes from v8 to v8.1
Chapter 1 Aged Care Act 2024	Introduces some key concepts under the *Aged Care Act 2024* that are important to understand. • Changes to eligibility requirements to access aged care services • Service list and structure under *Aged Care Rules 2025* • Approvals under *Aged Care Act 2024* • Transition arrangements	• Definitions of homeless and at risk of homelessness (section 1.4.2) • Inclusion of Transition arrangements to the Aged Care Act (section 1.5) • Update to the alternative entry section to clarify TCP arrangements (section 1.6)
Chapter 2 Overview of My Aged Care and Single Assessment System	Provides information about My Aged Care and the Single Assessment System including: • Introduction of Aboriginal and Torres Strait Islander Assessment Organisations from August 2025 • Assessment Organisation roles and responsibilities • Assessment types • The Integrated Assessment Tool (IAT)	• Information about recording a client's preference for an Aboriginal and Torres Strait Islander Assessment Organisation (section 2.1) • Updates to Supporting Community Engagement about the Aboriginal and Torres Strait Islander pathway (section 2.5) • Further information regarding supporting the broader roll-out of Aboriginal and Torres Strait Islander Assessment Organisations (section 2.5.1) • Multi-disciplinary approach (section 2.8.5) and Aboriginal and Torres Strait Islander people • Inclusion of culturally appropriate Validated Assessment Tools for Aboriginal and Torres Strait Islander people (section 2.11.1)
Chapter 3 Referral, Registration and Screening	Details the referral, registration and screening stages of the assessment journey. Information includes: Registered supporters • Entry into My Aged Care • Registering with my aged care • Screening • Alternative entry (urgent services pathway) • Application for Care form	• Updates to entry into My Aged Care (section 3.1) • Clarification of alternative entry arrangement for TCP (section 3.4) • Updates to Emergency Residential Care- Application for Care (section 3.6)

Chapter	What you'll find in this chapter	Key Changes from v8 to v8.1
Chapter 4 Referral for Assessment	Details the assessment referral process in the My Aged Care assessor portal including: • Managing and actioning referrals and assigning referral priority, • Managing preference for Aboriginal and Torres Strait Islander assessments • Explaining how priority categories are assigned to different assessments including Home Support, Comprehensive and Hospital Assessments • Using the End-of-Life Pathway 'high priority' referrals in the system • Explaining how assessors can self-refer for eligible and (likely) ineligible individuals. • SPRs and reassessment requests	• Additional information about a client's preference for an Aboriginal and Torres Strait Islander Assessment Organisation (see section 4.3.1) • Additional information about contacting Aboriginal and Torres Strait Islander people before rejecting a referral (section 4.3.8)
Chapter 5 Assessment Activities	Includes important information about how to undertake an aged care needs assessment and complete a support plan for an older person. This chapter includes: • Consent for triage and assessment • Triaging Assessments and Triage Delegate role • Triage for SPRs • Revocation of Eligibility • Undertaking a needs assessment using the IAT • Assessment settings • Clinical attendance • IAT outcome • Recommending service types and services • Converting a home support assessment to comprehensive • Support Plan • Wellness & Reablement • Linking Supports • Assessment wrap-up	• Triage timeframes for Aboriginal and Torres Strait Islander Assessment Organisations (section 5.2) • Informing an eligible younger person of other services (section 5.2.2) • Additional guidance for Triage Delegates to check a person's preference for Aboriginal and Torres Strait Islander Assessment Organisation (section 5.3.1) • Preparing for an assessment with an Aboriginal and Torres Strait Islander person (section 5.3.8) • Confirming an older person's preference for an Aboriginal or Torres Strait Islander Assessment Organisation prior to assessment (section 5.6.1) • Additional information on confirming if an individual identifies as a care leaver (section 5.7) • Guidance on how to use the IAT Outcome (section 5.7.7) • Linking supports- additional information for Aboriginal and

Chapter	What you'll find in this chapter	Key Changes from v8 to v8.1
		Torres Strait Islander AOs (section 5.10.2) • Making service recommendations - additional information for Aboriginal and Torres Strait Islander Assessment Organisations (section 5.12.1) • Review of Support Plan and Assessment Wrap up - additional information for Aboriginal and Torres Strait Islander Assessment Organisations (section 5.13 & 5.14)
Chapter 6 Aged Care Programs	Includes important information about the aged care programs recommended by assessors to meet an older person's needs and goals. • Introduction of Support at Home Program (classifications 1-8; RCP, EoL, AT-HM • Changes to CHSP and interactions with other programs	• Restorative Care Program (RCP) – information about RCP units (section 6.2) • RCP – call out box advising RCP cannot be recommended with Hoarding and Squalor services (section 6.2.3) • RCP- further information on the interaction between CHSP and RCP (section 6.2.4) • RCP – call out box regarding informing an older person an approval for ongoing Support at Home will end their RCP episode (section 6.2.5) • RCP - Manual oversight of RCP places (section 6.2.6) • Additional information on recommending transition care (section 6.8.2)
Chapter 7 Delegations and approvals under the Act	Includes information about: • The powers under the Aged Care Act 2024 that are delegated to Triage Delegates and Clinical and Non-Clinical Assessment Delegates. • How approvals work under the *Aged Care Act 2024*, and the decisions that delegates make.	• Approval of reasons under the Act – addition of visual summary (section 7.6.1) • Access approval pathway under section 66 of the Act – addition of visual summary (section 7.6.2) • Approvals under section 67 of the Act, person with impairment or sickness – addition of visual summary (section 7.6.3) • Approvals under section 68 individuals with sickness – addition of visual summary (section 7.6.4)

Chapter	What you'll find in this chapter	Key Changes from v8 to v8.1
Chapter 8 Delegate decisions in practice	Includes guidance for Assessment Delegates covering: • How to make sound, evidence-based decisions • step-by-step processes for approving aged care services across the service groups • Other approvals (including giving approvals after a service has commenced and approving a service without an assessment).	• Additional instructions on reviewing the assessment evidence (section 8.2.3) • Further instructions on deciding if an individual is eligible for home support and deciding a classification type and level (section 8.3.1 and 8.3.2) • RCP- manual oversight of RCP places (section 8.3.2) • Instructions on the AT-HM service seeking status (section 8.4.4) • Alternative entry – instructions regarding recording the emergency care start date (section 8.9.1)
Chapter 9 Finalising the Assessment and Service Referral	Includes guidance about: • Finalising the assessment • Recording and communicating the assessment outcome • Referring the older person for services, • The single provider model for Support at Home (which includes a single referral code for all services/pathways) • Completing the Notice of Decision (approval/non-approval letter).	• End-of-Life Pathway (EOL)- call out box about EoL and receiving the 'Non-approval letter' (section 9.3.1)
Chapter 10 SPRs and Reassessments	Includes guidance on the circumstances for conducting a Support Plan Review (SPR) or a reassessment for each aged care program.	• Additional instructions on prioritising support plan reviews (SPRs) for End-of-Life and second units of restorative care (section 10.1.2)
Chapter 11 Reviewable Decisions, Revocations and Complaints	Provides information on assessment related reviewable decisions in accordance with the *Aged Care Act 2024*. It also details: • The reconsiderations process • Options for reviews and revocations • The complaints process.	• Departmental contact details for assessment related revocations (11.4.1) • Further instructions on corrections after a service referral has been accepted or services have commenced (section 11.5)
Chapter 12	Outlines the ways in which the aged care system supports an older person's diverse needs by ensuring	• Further information on understanding cultural safety for

Chapter	What you'll find in this chapter	Key Changes from v8 to v8.1
Supporting Diverse Experiences and Needs	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.	older Aboriginal and Torres Strait Islander people (section 12.2)
Chapter 13 Operating Procedures	Includes information on privacy, information management and relevant legislation. Also included in this chapter is information about: • Clinical governance • Information management and privacy under the *Aged Care Act 2024* • Framework for governance of Indigenous data • Branding • Resources for consumers • Reporting and performance	• Updates to privacy and protected information under the *Aged Care Act 2024* (section 13.2.1)
Chapter 14 Fees and Payments	Provides guidance on fees, payments and participant contributions for funded aged care services.	• Revised information on fees for older people entering permanent residential care (section 14.2.3) • Revised information on financial hardship (section 14.2.4) • Revised information on fees payable by older people receiving transition care (section 14.2.5)
Appendices	Appendices include: • Overview of changes to assessment processes under the Act • Glossary • Contact Details • Clinical Governance Guidance for Aged Care Needs Assessment Organisations • Clinical attendance • Wellness and Reablement • Restorative Care Case Studies • Aged Care Assessment Workforce Credentials	• New visual that provides an overview of changes in the assessment processes under the *Aged Care Act 2024* (Appendix A) • Additional information for Aboriginal and Torres Strait Islander Assessment Organisations (Appendix G)

1. Chapter 1: Aged Care Act 2024

What you'll find in this chapter

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

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

All sections in this chapter are new content.

1.1. About the Aged Care Act 2024

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

The Act upholds these rights through:

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

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

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

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

Chapter 1 – Introduction
This Chapter establishes the purpose, objectives, and scope of the Act. It introduces the key principles that underpin the Act, including the Statement of Rights and the Statement of Principles, which recognise the rights, dignity, and autonomy of older Australians. The

Chapter also defines important concepts and terminology used throughout the Act, ensuring consistency in interpretation and application. This Chapter also includes the aged care service list (Prescribed in the Aged Care Rules 2025 in Part 3).

Chapter 2 – Entry to the Australian Aged Care System

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

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

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

Chapter 4 – Funding of aged care services

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

Chapter 5 – Governance of the aged care system

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

Chapter 6 – Regulatory mechanisms

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

Chapter 7 – Information management

This Chapter establishes the rules for handling aged care data, privacy, and information sharing. It sets out record-keeping requirements for providers and government agencies and outlines protections against the misuse of sensitive personal information. The Chapter also

introduces whistleblower protections and mechanisms for publishing key information about aged care providers and services, ensuring transparency and public trust in the system.

Chapter 8 – Miscellaneous

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

Subordinate legislation

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

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

1.2. Statement of Rights and Principles

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

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

Figure 2 – Aged Care Act 2024 (Cth) Statement of Rights and Principles

1.2.1. The Statement of Rights

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

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

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

1.2.2. The Statement of Principles

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

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

1.3. Dignity of risk

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

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

1.4. Eligibility requirements to access government funded aged care services

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

This means that all services are Act-based services under the Act from 1 November 2025, including services that an older person accesses through a specialist aged care program (e.g. Commonwealth Home Support Program, Multi-purpose Service Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Transition Care Program).

1.4.1. Age eligibility requirements

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

Note:

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

-aged 65 or over; or

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

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

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

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

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

1.4.2. Informing the eligible younger person of other services

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

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

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

Note:

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

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

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

Homeless definition

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

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

At risk of homelessness definition

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

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

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

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

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

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

As part of the commencement of the *Aged Care Act 2024 (the Act)* on 1 November 2025, there are different transitional arrangements for existing clients and new clients being assessed as eligible for aged care programs.

A general 'no worse off' principle applies to all older people who will transition under the Act. Assessors should follow the procedures outlined in Table 1 when managing approvals for this cohort.

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

Table 1: Transitional Rules from 1 November 2025

Cohort	Transitional Rules from 1 November 2025
Home Care Package (HCP)	• All HCP recipients transition to Support at Home. - Assigned one of four Transitioned HCP classifications based on their current HCP level. • No Support at Home classification (Levels 1–8) assigned at transition. • Transitional classification can be retained indefinitely, even after reassessment, if more beneficial.
Multi-Purpose Services Program (MPSP)	• Home/community services recipients (or those starting within 3 months) automatically approved for: - Ongoing/short-term home support - Assistive Technology (AT) - Home Modifications (HM) • Residential aged care recipients (or those starting within 3 months) approved for ongoing/short-term residential care.
NATSIFACP	• Individuals receiving NATSIFACP services in the 12 months before 1 Nov 2025 are automatically eligible under the Act. • No new assessment required unless care needs change. • All new clients post 1 November are required to make an application for funded aged care services by registering with MAC, undergo a needs assessment and obtain an access approval for one or more service groups in place to access services delivered under NATSIFACP. • However, they can receive NATSIFACP services before assessment if they meet the criteria for alternative entry.
Commonwealth Home Support Programme (CHSP)	• Registered and assessed clients automatically transition and continue accessing services. • Unregistered and unassessed clients must be assessed by 31 October 2025 to continue accessing services. • Grandfathered clients (from pre-2015 programs) who have never been assessed must undergo an assessment. • Under the transitional arrangements and under section 71 of the Act, CHSP clients who have accessed a CHSP service by 31 October 2025 and are awaiting assessment on or after 1 November

Cohort	Transitional Rules from 1 November 2025
	can have their service approval backdated to 1 November if they are found eligible at assessment
Short-Term Restorative Care (STRC) ***(known as RCP from 1 Nov)***	• The STRC Programme will change to the 'Restorative Care Pathway' under Support at Home as of 1 November 2025. • STRC clients who commence their care episode before 1 November 2025, and are still in flight on 1 November, will have their care continue under transitional arrangements. • those approved for STRC that commence their care episode after 1 November 2025, will have their STRC approval converted into an approval for the Restorative Care Pathway. They will also receive approval for assistive technology medium tier and home modifications medium tier. • They will have six months from their STRC approval to access the Restorative Care Pathway/AT-HM. • After this, they will need to be reassessed to access restorative care or AT-HM under the Support at Home program, if eligible.
Younger People	• Younger people already accessing services will not be required to have a reassessment. • Younger people currently accessing services will be able to continue to access these services and also be eligible to be assessed for other aged care services in the future. • Younger people, in the process of applying for aged care services on 1 November, will be eligible to be assessed under relevant criteria within the *Approval of Care Recipients Principles 2014*.
Transition Care Program (TCP)	• Current Transition Care Program clients who continue to receive care across the transition from the old to Act will have their eligibility and approval deemed across. • All new clients post 1 November will be required to have a comprehensive assessment and receive delegate approval, before they are discharged from hospital, to be referred to transition care service provider.
Residential Care	• Existing residents in care on 1 November 2025 will be allocated a place to ensure no payment or continuity of care issues for the provider or older Australian. This cohort of older Australians will not need to do anything to facilitate this allocation. This will happen as part of the transition to the Act. • Older Australians who have been assessed and approved as requiring residential care, prior to 1 November 2025, will be

Cohort	Transitional Rules from 1 November 2025
	automatically allocated a place and can enter care when they choose to.

1.5.1. Transitioned Home Care Package

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

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

Table 2: Transitioned levels and recommended outcomes

Transition level	IAT Outcome	Recommended outcome
Transitioned HCP 1	CHSP Support at Home Classification 1	Retain Transitioned HCP 1
	Support at Home Classification 2-8	Use recommended Support at Home 2-8 Class.
Transitioned HCP 2	CHSP Support at Home Classification 1-2	Retain Transitioned HCP 2
	Support at Home Classification 3-8	Use recommended Support at Home 3-8 Class.
Transitioned HCP 3	CHSP Support at Home Classification 1-5	Retain Transitioned HCP 3

Transition level	IAT Outcome	Recommended outcome
	Support at Home Classification 6-8	Use recommended Support at Home 6-8 Class.
Transitioned HCP 4	CHSP Support at Home Classification 1-7	Retain Transitioned HCP 4
	Support at Home Classification 8	Use recommended Support at Home 8 Class.

Section 6.7 Classification of the Support at Home Manual.

1.5.2. Support Plan Reviews for transitioned Home Care Package (HCP) clients

Transitioned HCP clients will continue to be eligible for Support Plan Reviews (SPRs) under the same process currently in place. However, in line with existing procedures, if it is determined that a client's circumstances have changed and they now require services at a higher level, a reassessment will be required.

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

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

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

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

If a transitioned HCP recipient has no HCP unspent funds and requires AT-HM, the provider can, with consent from the participant, refer them for a new assessment by an aged care needs assessor. Between 1 November 2025 and February 2026, HCP recipients transitioning to Support at Home, that don't have any unspent funds or have insufficient unspent funds to meet their need for assistive technology and home modifications, can agree for providers to supply information indicating any additional funding needs through the AT-HM scheme data collection process, where the department delegate may allocate an AT ongoing and/or AT/ HM low, medium or high short term funding tier.

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

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

AT-HM List

1.5.4. Multi-Purpose Service Program (MPSP)

Existing MPSP clients on 1 November 2025

There will be transitional arrangements in place for individuals already accessing services under the MPSP to provide for service continuity.

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

An individual accessing aged care services in a home or community setting through a MPSP provider at transition time, or who has an agreement in place to commence these services

within 3 months of the transition time, will be approved for ongoing and short-term home support, as well as short-term AT and HM.

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

Note:

Individuals will have their transitional status confirmed in writing, via a notice given to their provider after 1 November 2025. This letter will also be attached to their My Aged Care Client Record. By June 2026, relevant approvals and referrals will also be retrospectively added to Department of Health and Aged Care systems to facilitate these individuals moving between MPSP and mainstream services in future.

If an older person in one of the transitional cohorts above wants to access mainstream aged care services (outside the MPSP) after 1 November 2025:

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

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

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

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

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

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

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

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

Note: For clients who have been assessed post 1 November 2025 and want to leave their MPSP provider and access mainstream aged care services:

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

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

A fact sheet is available for people leaving the MPSP to access other services, to ensure they are aware they might need to wait for services to become available and could pay higher fees. The fact sheet also provides more information on the process for people leaving the MPSP.

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

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

Existing NATSIFACP clients

There will be transitional arrangements in place for individuals who have accessed services under the NATSIFACP in the 12 months leading up to 1 November 2025 to ensure service continuity.

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

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

Note:

Individuals will be notified of their status post 1 November 2025 in writing via a notice given to their provider. This letter will also be updated to their My Aged Care Client Record in late 2025, and relevant service recommendations and referrals will also be retrospectively added to Department of Health, Disability and Ageing's systems at this time.

If an older person in one of the transitional cohorts above wants to access mainstream aged care services post 1 November 2025:

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

seek to undergo an aged care needs assessment if they only have a default NATSIFACP classification level provided at transition time, or

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

if they plan to access mainstream services in a residential care home: they will need to undergo a Residential Aged Care funding assessment (i.e. a classification re-assessment) and an aged care assessment if they have not had one previously.

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

All new clients post 1 November are required to make an application for funded aged care services, by registering with MAC, undergo a needs assessment and obtain an access approval for one or more service groups in place to access services delivered under NATSIFACP. However, they can receive NATSIFACP services before assessment if they meet the criteria under alternative entry provisions.

1.5.7. Commonwealth Home Support Program (CHSP)

Registered and assessed Commonwealth Home Support Program (CHSP) clients will automatically transition under the Aged Care Act 2024 (the Act) on 1 November 2025. These clients will continue accessing their current CHSP services in line with their assessed need, without taking any action.

Unregistered and unassessed clients must have registered with My Aged Care and be assessed as eligible for the CHSP by 31 October 2025, to continue accessing government funded aged care services from 1 November 2025.

Note:

Backdating is available for CHSP clients who applied for an assessment before 1 November

Transitional rules have been drafted to enable backdating of approvals if unassessed clients apply for an assessment by 31 October.

This means all current CHSP clients who are assessed as eligible after the commencement of the new Act can have their CHSP approvals backdated to November.

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

1.5.8. Short-Term Restorative Care (STRC) Programme

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

- STRC Programme participants who commence their care episode before 1 November 2025 and are still in flight on 1 November. These participants will have their care continued under transitional arrangements.

- Participants approved for the STRC Programme but commence their care episode after 1 November 2025. These participants will have their STRC approval converted into an approval for the Restorative Care Pathway.

    - They will also receive approval for assistive technology medium tier and home modifications medium tier. They will have six months from their STRC approval to access the Restorative Care Pathway/AT-HM.

    - After this, they will need to be reassessed to access restorative care or AT-HM under the Support at Home program, if eligible. A second unit of funding to use within a single Restorative Care Pathway episode can be requested via a Support Plan Review request.

    - The assessor will need to self-refer this to undertake a reassessment to grant access to a second unit of funding. This is because the ability to add a second unit via SPR will not be available on the assessor portal for those with an STRC approval. The reassessment can be done over the phone and does not require queuing for a face-to-face assessment. While the system may allow a 'third' unit of concurrent RCP funding to be requested by the provider, assessors should check to ensure a person is not approved for another unit once the initial and second have been approved.

    - Requests for higher levels of AT funding will also need to follow this process. Please note, a request for high-tier AT will require recommendation and also approval for a Support at Home classification. Approval for RCP will result in a second unit of RCP funding being given and all evidence requirements must be met. Approval for an ongoing Support at Home classification will conclude their RCP episode.

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

1.5.9. Transition Care Program (TCP)

Current TCP clients who will continue receiving transition care from 1 November 2025

Current Transition Care Program clients who continue to receive care across the transition to the Act will have their eligibility and approval deemed across.

New TCP Clients post 1 November 2025

All new clients post 1 November will be required to have a comprehensive assessment and receive delegate approval, before they are discharged from hospital, to be referred to transition care service provider.

1.5.10. Residential Care

Current residential care clients who will continue receiving residential care from 1 November 2025

Existing residents in care on 1 November 2025 will be allocated a place to ensure no payment or continuity of care issues for the provider or older Australian. This cohort of older Australians will not need to do anything to facilitate this allocation. This will happen as part of the transition to the Act.

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

Older Australians who have been assessed and approved as requiring residential care, prior to 1 November 2025, will be automatically allocated a place and can enter care when they choose to.

1.5.11. Younger People

Younger people receiving existing aged care services

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

A “no worse off” principle will also apply to individual contributions for younger individuals transitioning to receiving services under the Act. Should the care needs of younger individuals change post 1 November 2025, they will be eligible for reassessment to access residential aged care. These individuals may be eligible for reassessment for other aged care services based on program level transition rules.

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

Younger people with 'In-flight assessments'

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

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

A younger person who has registered with these services on or before 31 October but is yet to register with My Aged Care is still considered to have commenced an assessment process so will still be eligible to receive an assessment post 1 November. The AFA and NDIA reports will clearly document the date on which the younger person commenced registration with the service.

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

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

1.6. Alternative entry

Under section 71 of the Act, an older person can access aged care services prior to an assessment occurring under 'alternative entry' pathways.

Three circumstances for 'alternative entry' are outlined in **subsection 71(4)**:

- **Urgent services**: The individual was in urgent need of access to funded aged care services and there was a significant risk of harm to the individual if services were not provided before an approval was given;
- **Lack of availability of culturally safe assessments**: The individual is an Aboriginal and/or Torres Strait Islander person and at the time the individual sought access to funded aged care services, there was a lack of availability to access a culturally safe assessment
- **Services commenced through a specialist aged care program and there is a significant delay in assessment**: The individual started to receive care from a specialist aged care program (such as CHSP, MPSP or NATSIFACP) before approval was given and at the time the individual sought funded aged care services there was a significant delay in the availability to undertake a needs assessment.

To access any of the alternative entry pathways, an individual must apply for an assessment in an approved form within the time period specified in the Act and *Aged Care Rules 2025*.

Individuals have a period of 5 days after the day services commenced to make an application under section 71 of the Act. The *Aged Care Rules 2025* specify one exception, if the registered provider delivering services is a NATSIFACP or MPSP provider. In this instance the individual has 30 days after the day on which care commenced to make an application.

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

Further information on alternative entry is available in Chapter 3.

1.7. Aged Care Service List

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

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

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

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

The Aged Care Service List serves several key functions:

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

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

1.8. Service groups

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

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

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

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

Note:

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

1.9. Approvals under the *Aged Care Act 2024*

There is a conceptual shift in the way that the Act describes and groups together approvals. Rather than focusing on programs, approvals under the Act revolve around three primary components that, when combined, are comparable to 'being approved for a program' under the *Aged Care Act 1997*. The components are 'Service group', 'Classification type' and 'Classification level' (sometimes simply referred to as 'Classification'). A priority category is also applied in some circumstances.

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

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

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

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

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

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

Table 5: Service group: Home support

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

Table 6: Service group: Assistive technology

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

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

Table 7: Service group: Home modifications

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

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

Table 8: Service group: Residential care

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

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

1.10. Deciding if the older person requires aged care services

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

This decision is made based on:

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

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

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

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

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

Important:

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

1.10.1. Approvals for service types and services

The Aged Care Service List service is defined in the Aged Care Rules 2025. It lists the four service groups, and the service types and services within them. See Chapter 7 for further information on how service types and services are approved for different cohorts and across different service types.

1.10.2. Approvals for priority categories

The priority categories assigned to individuals (under section 86 of the Act) determine when certain services are allocated under section 92 of the Act. These categories are based on the assessed urgency of need, complexity of care requirements, and potential risks associated with delayed support. Please see Chapter 7 for further information on how priority category decisions are made.

1.10.3. Period of effect of approvals

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

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

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

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

Please see Chapter 7 for further information on how periods of effect apply to access approval, classification level, and priority category.

1.11. Accessing funded aged care services

Under the *Aged Care Act 2024 (the Act),* older people will access funded aged care services through the following:

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

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

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

1.12. Where approvals can be used

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

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

Note:

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

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

You don't need to remember all of the details below – the systems, tools and templates you use will take these into account and/or prompt you when needed.

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

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

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

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

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

What you'll find in this chapter

This chapter provides information on the Single Assessment System including:

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

2.1. My Aged Care

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

The key elements of My Aged Care include:

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

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

- a central older person record that will include each older person's current aged care requirements and associated history and services provided through My Aged Care
- ability to request, register and end registered supporter relationships
- a referral capability that enables the contact centre, ACSOs and assessors to find appropriate assessment, home support, residential and community support services or resources for older people
- web-based portals for older people (My Aged Care Online Account), assessors, service providers and support organisations.

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

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

My Aged Care is committed to supporting older Aboriginal and Torres Strait Islander people and their carers by making it easier to access aged care assessment services that are respectful of culture, community, and connection to Country. Through Aboriginal and Torres Strait Islander assessment organisations, assessment services recognise the importance of cultural safety, trust, and relationships. Information, assessment and support will also be delivered in ways that promote wellbeing.

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

In anticipation of the phased implementation of Aboriginal and Torres Strait Islander Assessment Organisations from August 2025, older Aboriginal and Torres Strait Islander people have been able to indicate their preference to have their assessment delivered by an Aboriginal and Torres Strait Islander assessment organisation since February 2025.

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

It is recognised that building trust can take time, particularly for older Aboriginal and Torres Strait Islander people who may need to feel safe and comfortable before sharing personal or sensitive information with assessors. To support this, assessments may be conducted over multiple sittings if required to allow the process to proceed at a pace that respects the older person's readiness and preferences. During this period, assessors are expected to maintain regular contact with the older person to ensure continuity while the assessment remains active. This ongoing engagement helps foster trust and continuity and ensures that the older person feels supported throughout the process.

Note:

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

2.2. Single Assessment System

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

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

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

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

The department has responsibility for the Single Assessment System, including providing advice on Australian Government policy, the monitoring and reporting of performance

against agreed service levels, and the management of regulatory and other administrative processes relating to the Act.

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

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

2.3. Aboriginal and Torres Strait Islander assessment organisations

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

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

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

Aboriginal and Torres Strait Islander assessment provides a dedicated pathway that is more culturally appropriate and attuned to the cultural needs of older Aboriginal and Torres Strait Islander people. Embedding cultural safety into the assessment process will help improve the experience of older Aboriginal and Torres Strait Islander people, as well as their families and carers, thereby encouraging the uptake of aged care services by older Aboriginal and Torres Strait Islander people. This will support them to maintain their independence at home for longer.

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

These organisations provide older Aboriginal and Torres Strait Islander people:

- an improved assessment experience

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

Aboriginal and Torres Strait Islander assessment organisations work closely with local Aboriginal and Torres Strait Islander community organisations, and support networks such as Aboriginal Community Controlled Organisations, Aboriginal Community Controlled Health Organisations, and the Elder Care Support program. They work together to promote, educate and encourage the older Aboriginal and Torres Strait Islander people and their community to identify their needs and consider how aged care can help them age well and support them to stay at home and on Country longer.

This network will also help older Aboriginal and Torres Strait Islander people engage safely with the aged care system and help receive supports they need. Older Aboriginal and Torres Strait Islander people can access aged care needs assessments through the existing assessment organisations, or, once established, through an Aboriginal and Torres Strait Islander assessment organisation if available in their area.

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

Aboriginal and Torres Strait Islander Assessment Organisations are expected to:

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

- Single Assessment System for aged care | Australian Government Department of Health, Disability and Ageing
- Aboriginal and Torres Strait Islander Assessment Organisations

- Interactive map of available services
- Fact Sheet for assessors

2.4. Overview of assessment organisation roles and responsibilities

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

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

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

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

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

Role Title	Role type	Role Description
Contract manager	Business	Contract Managers, manage and report the assessment services and performance specified in the organisation's agreement with the Commonwealth. Contact point for the department for contract management.
Assessment Organisation Operational Manager	Business and System	Assessment Organisation Operational Managers, manage the delivery of assessment services specified in the organisation's agreement with the Commonwealth at an operational level. Operational managers may also hold organisational or outlet administration roles in the My Aged Care assessor portal.

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

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

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

My Aged Care Assessor Portal - Organisational Administrator User Guide

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

Culturally safe assessments are everyone's responsibility.

As Aboriginal and Torres Strait Islander Assessment Organisations are embedded within communities, these organisations are well placed, as trusted intermediaries, to inform their communities about the availability of the Aboriginal and Torres Strait Islander Assessment pathway through various channels suitable to the community.

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

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

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

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

These organisations and broader community engagement will provide advice,

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

2.6. Training requirements for assessment teams

The My Aged Care Workforce Learning Strategy 2025 (Workforce Learning Strategy), and subsequent editions of this strategy defines and sets the mandatory minimum training requirement for the Single Assessment System workforce and the My Aged Care workforce, including timeframes for completion. Training occurs as part of the staff members induction into the assessment organisation. Some roles have mandatory credential requirements. Details of these credential requirements are provided in Attachment F. The assessment organisation is responsible for validating that each person has the required credentials for their role before requesting registration for training.

The department and assessment organisations are jointly responsible for training assessment organisation staff. The Workforce Learning Strategy explains the blended approach to mandatory training requirements including on-line training, on-the-job learning and learner appraisal. This approach reflects that the Single Assessment System

workforce and My Aged Care workforce undertakes functions broader than just screening and assessment. This approach also acknowledges existing knowledge and skills of the workforce, and that learning is ongoing.

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

2.6.1. Training delivery

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

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

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

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

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

- My Aged Care Workforce Learning Strategy 2025
- My Aged Care Quality Learning Framework
- New training and learning system for My Aged Care workforce

2.7. The single assessment pathway

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

Upon accepting an assessment referral, Aboriginal and Torres Strait Islander Assessment Organisations are expected to actively engage with the older person as well as their

support networks. This may include but not limited to, Elder Care Support Staff, care finders, aged care providers, GPs, Aboriginal Community Controlled Health Organisations, social workers, and other relevant parties who may have facilitated the older person to access the aged care system, to understand the needs of the older Aboriginal and Torres Strait Islander person.

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

It is recognised that building trust can take time, particularly for older Aboriginal and Torres Strait Islander people who may need to feel safe and comfortable before sharing personal or sensitive information with assessors. To support this, assessments may be conducted over multiple sittings if required to allow the process to proceed at a pace that respects the older person's readiness and preferences. During this period, assessors are expected to maintain regular contact with the older person to ensure continuity while the assessment remains active. This ongoing engagement helps foster trust and continuity and ensures that the older person feels supported throughout the process.

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

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

Assessment Organisations (including those that are Aboriginal and Torres Strait Islander) may deliver assessments through subcontracting arrangements subject to approval from the department.

2.7.1. Home support assessments

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

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

During the assessment, questions may be prompted in the IAT that require clinical judgement. These questions (referred to as clinical questions) will need to be asked in

accordance with the assessment organisation's clinical governance framework and standard operating procedures.

At the end of the assessment, the assessor may determine that the older person has intensive and complex care needs and cannot be supported to live at home independently with small amounts of entry-level support. . In these circumstances the assessment must be converted to a comprehensive assessment in the IAT before Support at Home or Residential Aged Care can be added to the support plan (see Chapter 5). If this conversion is initiated by a non-clinical assessor, they will need to seek the supervision of a clinical assessor in accordance with their organisation's clinical governance framework and standard operating procedures. The Support Plan will be submitted for approval by a clinical assessment delegate, and a Notice of Decision will be generated and sent to the older person and any of their registered supporters who are entitled to receive this information.

2.7.2. Comprehensive assessments

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

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

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

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

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

2.8. Other assessment activities

2.8.1. Support Plan Reviews (SPR)

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

2.8.2. Wellness and reablement

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

2.8.3. Linking support

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

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

2.8.4. Assessment delegation

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

- Triage Delegates

- Non-clinical Assessment Delegates
- Clinical Assessment Delegates

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

2.8.5. Multi-disciplinary approach

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

Multidisciplinary approach to aged care assessment for older Aboriginal and Torres Strait Islander people should goes beyond a clinical assessment and should consider the client's social, emotional, and cultural wellbeing. It may involve collaboration with other professionals, social workers, community members, as part of the assessment. This is to ensure the assessment is holistic, culturally safe and responsive to the person's needs.

2.9. Aims and key features of assessment

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

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

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

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

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

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

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

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

2.10. Assessment quality

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

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

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

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

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

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

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

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

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

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

2.11. Integrated Assessment Tool (IAT)

The IAT was developed in response to aged care reforms. These reforms form of the Australian Government's response to recommendations from the Royal Commission into Aged Care Quality and Safety.

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

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

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

IAT Offline Form

IAT User Guide

2.11.1. Validated Assessment Tools

Where appropriate, assessors should consider using culturally appropriate validated tools within the IAT to deliver culturally safe, trauma aware and healing informed assessments. These tools are detailed in Table 11

Table 12. Validated culturally appropriate assessment tools

Validated culturally appropriate tool	Short description
Good Spirit Good Life (GSGL):	The GSGL addresses gaps in health and aged care by providing a culturally-informed approach to measuring, understanding and meeting the quality of life of older First Nations people. The tool measures wellbeing using 12 interconnected factors which are important to the First Nations people, such as family and friends, connection to Country, community, culture, health, respect, their role as an Elder, support services, safety and security, spirituality, future wishes and basic needs being met. Guidance on Good Spirit Good Life is available at: https://www.aboriginalageingwellresearch.com/gsgl-resources (registration required to view) This tool is available in the Integrated Assessment Tool (IAT).
KICA Cog	The only validated dementia Assessment tool for older Indigenous Australians. It is recommended for use with rural and remote Indigenous Australians aged 45 years and above for whom other dementia assessments are not suitable. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element **Validated Assessment Tools in Practice** for further guidance on how and when to

Validated culturally appropriate tool	Short description
	administer this validated tool with a client at an assessment. • KICA COG • Instruction Booklet This tool is available in the Integrated Assessment Tool (IAT).
KICA Cog Urban Regional	KICA was modified for use with Aboriginal people in regional and urban settings. The regional and urban KICA is an instrument to assess dementia in older Aboriginal people in regional and urban settings. **Additional information and training resources:** Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element **Validated Assessment Tools in Practice** for further guidance on how and when to administer this validated tool with a client at an assessment. • Guidance on the KIKA Cog Urban Regional is available at Indigenous Cognitive Assessment: Regional and Urban KICA | National Ageing Research Institute Limited (nari.net.au) This tool is available in the Integrated Assessment Tool (IAT).
KICA Carer	The KICA-Carer is an informant questionnaire given by the interviewer. It is the informant cognitive subsection of the KICA that was developed and validated in the Kimberley region of WA. • Kimberley Indigenous Cognitive Assessment – KICA-Carer

Validated culturally appropriate tool	Short description
	This tool is available in the Integrated Assessment Tool (IAT).
KICA – COG Torres	Not currently included in the IAT. This validated tool has been adapted to be culturally relevant to Torres Strait Islander people in Far North QLD

3. Chapter 3: Referral, registration and screening

What you'll find in this chapter

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

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

3.1. Entry into My Aged Care

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

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

Where an older Aboriginal and Torres Strait Islander person or their advocate approaches an Aboriginal and Torres Strait Islander assessment organisation , it may be most culturally appropriate for the assessment organisation to self-refer the client for an aged care assessment. The assessor can then assist the client with the registration and triage process to determine eligibility for an assessment. This support could be provided in person to ensure a culturally safe experience. Self-referral can also be used in other settings, described at section 4.4 in Chapter 4.

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

Note:

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

3.1.1. Modes of entry into My Aged Care

Phone

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

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

Online

Apply for an assessment online

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

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

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

Web referrals (Make a Referral form)

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

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

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

If the GP or health professional recommends a comprehensive assessment and the older person has previously been assessed for a home support assessment, the web referral will be intercepted by the My Aged Care Contact Centre and follow the SPR pathway rules to the assessment organisation that undertook the most recent assessment,

regardless of the recommendation (unless the request qualifies for a direct comprehensive assessment referral, such as for TCP).

GP e-Referral

GPs may also choose to use GP e-Referrals which can be accessed from their practice management system. The form will pre-populate the patient's information with the GP then adding any additional information and attachments as required. It is then submitted safely and securely to My Aged Care for processing and will follow a similar process to that outlined for the Make a Referral form.

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

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

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

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

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

Services Australia website: Aged Care Specialist Officer

3.1.2. My Aged Care Online Account

Create account and registration

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

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

3.2. Support networks for an older person

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

3.2.1. Registered supporters

Supported decision-making in aged care legislation

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

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

Role of registered supporters

Chapter 1, Part 4 of the Act establishes the role of a registered supporter. The registered supporter role is one of the changes under the Act that aim to promote older peoples' rights to be supported to make their own decisions. This role starts on 1 November 2025. The registered supporter role replaces existing regular and authorised representative relationships in My Aged Care.

When the Act starts, older people can still choose who can support them to make decisions, if they want or need support. These people can be registered supporters. A registered supporter can be a trusted family member or friend or anyone else of an older person's choosing, who can help them to request, access and understand information and communicate their wishes.

Registered supporters can:

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

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

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

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

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

Active, appointed decision makers

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

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

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

Consent and registered supporter types

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

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

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

- Supporter – a person who the older person consented to registering as a supporter **and** to be automatically given information and documents that may or must be given to the older person under the Act.

- Supporter lite – a person who the older person consented to registering as a supporter but **not** to be automatically given information and documents that may or must be given to the older person under the Act.

- Supporter guardian – a person who is registered by the System Governor as a supporter and who also has active decision-making authority for the older person by virtue of a Commonwealth, state or territory arrangement.

The following table summarises these types and the consent requirements:

Table 13. Supporter relationships and consent requirements

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

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

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

Suspension and cancellation of a registered supporter

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

cancelled, a supporter's registration has no effect, and an assessor cannot engage with that person as a registered supporter.

The processes of suspension and cancellation are detailed in the Act and intend to promote the safety and wishes of an older person. More information on these processes can be found on the department's website from 1 November.

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.

No requirement to register a supporter

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

Transitioning to the registered supporter role

Most representative relationships in My Aged Care will go through changes to come under the Act. If an older person has a regular or authorised representative active in My Aged Care on 31 October 2025, they will become and be known as a registered supporter under the Act on 1 November 2025. This ensures that older people seeking or receiving aged care services will continue to have decision-making support available to them.

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

Representative arrangements made under the Quality of Care Principles 2014 will no longer exist once the Act comes into effect. Further, these arrangements will not automatically transition to the Act. These representatives are encouraged to become registered supporters under the Act.

Supported decision-making in assessments

From 1 November, assessors should promote an older person's right to make decisions, engage with registered supporters in line with the older person's will and preferences, and embed supported decision-making in assessment delivery.

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

This might look like:

- Asking the older person to make decisions about their aged care services and needs (rather than deferring to their family, registered supporters or their active, appointed decision-maker),
- Checking whether an older person has a registered supporter, and whether the older person wants that person to provide support. Remember that having a registered supporter does not mean that the older person needs to include them in discussions and their decision-making processes. It is always up to the older

person. A registered supporter can only act in line with the older person's will and preferences, and

- Considering how supported decision-making principles can be embedded into an assessment process. This could be:
  - more time for the older person to explore options and only asking them to make one decision at a time,
  - presenting the older person with options in ways the older person prefers, such as visually, and
  - encouraging and supporting the older person to make decisions at a time and place most comfortable for the older person.

- Key information and pathways to request to register a supporter: www.myagedcare.gov.au/registering-supporter
- Information on appointed decision makers: www.myagedcare.gov.au/registering-supporter/appointed-decision-makers
- Registered supporter resource library, including policies: https://www.health.gov.au/resources/collections/registered-supporter-resources
- Guide to using the Assessor Portal
- My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships
- Provide access to language support service such as accessing an interpreter or translated documents: https://www.health.gov.au/topics/aged-care/translating-and-interpreting-services-for-aged-care
- Information about transitional arrangements in place for My Aged Care representatives before 1 November 2025:
  - Transition arrangements for the new registered supporter role | Australian Government Department of Health, Disability and Ageing
  - My Aged Care website: Upcoming changes to support roles and relationships | My Aged Care

3.2.2. Agent organisations

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

Upcoming changes to support roles and relationships | My Aged Care

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

3.3. Screening

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

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

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

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

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

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

3.3.1. Outcomes of screening

On completion of the screening:

- Assign referral priority to indicate the timing of the assessment and the urgency in which services are delivered to an older person, which is based on an older person's level of function, the level of risk in relation to the care situation and any other relevant concerns.
- Send the referral to an appropriate assessment organisation with the older person's consent.
- For urgent referrals for the End-of-Life Pathway, ensure the referral is marked as 'End-of-Life'.
- Send urgent service referrals to a CHSP provider with the older person's consent and send an assessment referral.

Note:

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

3.4. Alternative entry

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

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

- **Urgent services**: The individual was in urgent need of access to funded aged care services and there was a significant risk of harm to the individual if services were not provided before an approval was given;
- **Lack of availability of culturally safe assessments**: The individual is an Aboriginal and Torres Strait Islander person and at the time the individual sought access to funded aged care services, there was a lack of availability to access a culturally safe assessment
- **Services commenced through a specialist aged care program and there is a significant delay in assessment**: The individual started to receive care from a specialist aged care program (such as CHSP, MPSP or NATSIFACP) before approval was given and at the time the individual sought funded aged care services there was a significant delay in the availability to undertake a needs assessment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Screening

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

These services are:

- nursing
- transport
- meals
- personal care
- grocery shopping
- respite.

When issuing an urgent referral, the My Aged Care Contact Centre or ACSO will place a high priority on the referral to an assessment organisation. For an existing client who has

previously been assessed, the contact centre or ACSO will issue a SPR request (unless the older person meets the requirements for a direct comprehensive assessment referral).

Triage

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

Triage delegates should:

- Issue direct-to-provider referrals for CHSP services if the client requires the service and meets the criteria in subsection 71(4) of the Act
- Review any urgent service referrals that have been issued by the My Aged Care Contact Centre or ACSO and extend 'recommended end dates' if required
- Check all clients with an immediate health or safety need for services have a 'high' assessment priority.

Assessment

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

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

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

See information on Exceptional Circumstances below for clients who accessed CHSP services through the Alternative Entry pathway but do not undergo an assessment.

3.4.2. Residential care or residential respite care in urgent circumstances

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

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

3.5. Exceptional Circumstances – approving a service without an assessment

In some circumstances, a client may be eligible for an assessment but is unable to have one owing to exceptional circumstances. This typically occurs for a cohort that access funded aged care services through the alternative entry pathway but pass away prior to receiving an assessment.

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

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

If the assessment does not continue, but the Exceptional Circumstances clause applies, services already on the participant's support plan should remain listed when the triage delegate or assessor finalises the Notice of Decision and Support Plan.

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

Note:

For any other circumstance under the Exceptional Circumstances clause, an off-system process is to be undertaken. Assessment organisations are to contact the department in the first instance at MyAgedCare.Assessment@health.gov.au for assistance.

If assessment is cancelled or exceptional circumstances do not apply

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

3.6. Emergency Residential Care - Application for Care

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

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

Residential care (ongoing or short-term)

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

In completing the form**:**

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

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

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

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

3.6.1. Intake and assessment process

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

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

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

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

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

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

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

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

4. Chapter 4: Referral for assessment

What you'll find in this chapter

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

The following topics are covered in this chapter:

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

4.1. Managing referrals

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

4.2. Referral priority categories

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

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

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

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

4.2.1. Home support assessment priority categories

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

Table 14. Home support assessment priority categories

Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
High	Requires an urgent assessment based on the information collected during the referral process indicating the person would need to be hospitalised or leave their current residence without support because they are unable to care for themselves, or their carer is unavailable and/or has serious risks or safety hazards in their home. This may be due to a crisis in the home involving either the older person or the carer, or a sudden change in the older person or carer's medical, physical, cognitive, or psychological status. High priority referrals may also be accompanied by a direct-to-provider referral for urgent CHSP services (see Chapter 3 for more information on the Alternative Entry Pathway).	10 calendar days
Medium	Information available at referral indicates that the older person is not at immediate risk of harm, however there is a progressive deterioration in the older person's current status (physical, mental, cognitive, situational, functional), and/or the level of care that is currently available does not meet the older person's needs and is not sustainable long term.	14 calendar days
Low	Refers to cases where the referral information indicates that the older person has sufficient support at present and does not need immediate assistance but requires an assessment in anticipation of their upcoming care requirements. Examples include the carer planning a holiday which will result in the care recipient requiring the provision of substitute care, or recognition that the person is having increased difficulty living independently and options for care need to be discussed with the older person and their carer or family. Low priority cases would also indicate that an older person can manage with their current living arrangements, can complete most functional tasks without help, and/or there are no immediate aged care related health and safety risks apparent.	21 calendar days

4.2.2. Comprehensive assessment priority categories- community setting

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

Table 15. Comprehensive assessment priority categories – community setting

Priority Level	Definition	**Timeframes (from day of referral acceptance to completion)**
High	Requires an immediate response (e.g., response within 48 hours) based on the information collected during the referral process. An urgent assessment is required if the person's safety is at risk (e.g., high risk of falls or abuse), or there is a high likelihood that the person will be hospitalised or required to leave their current residence because they are unable to care for themselves, or their carer is unavailable. This may be due to a crisis in the home involving either the older person or the carer, or a sudden change in the older person or carer's medical, physical, cognitive, or psychological status. End-of-Life Pathway referrals are also in this category and should be prioritised for urgent action.	10 calendar days
Medium	Information available at referral indicates that the older person is not at immediate risk of harm. Referrals should be allocated to this priority category if they indicate progressive deterioration in the older person's physical, mental, or functional status, or that the level of care currently available to the older person does not meet their needs or is not sustainable in the long-term.	20 calendar days
Low	Refers to cases where the referral information indicates that the older person has sufficient support available at present, but that they require an assessment in anticipation of their upcoming care requirements. Examples include the carer planning a holiday, which will result in the care recipient requiring the provision of substitute care or recognition that the person is having increased difficulty living independently and options for	40 calendar days

Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
	care need to be discussed with the older person and their carer or family.	

4.2.3. Hospital assessment priority categories

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

Table 16. Hospital assessment priority categories

Priority Level	Definition	Timeframes (from day of referral acceptance to completion)
High	Requires an immediate response based on the information collected during the referral process (e.g., response within 2 calendar days and completion within 5 calendar days of referral acceptance).	5 calendar days
Medium	Information available at referral indicates that the older person is not at immediate risk of harm. Referrals indicate progressive deterioration in the older person's physical, mental, or functioning status, or that the level of care currently available to the older person does not meet their needs or is not sustainable in the long-term (e.g., response within 5 calendar days and completion within 10 calendar days of referral acceptance).	10 calendar days
Low	Information available at referral indicates an appropriate response within 10 calendar days and completion within 15 calendar days of referral acceptance).	15 calendar days

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

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

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

4.3. Actioning referrals

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

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

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

Some older Aboriginal and Torres Strait Islander people may prefer to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, others may prefer the first available organisation regardless of who it is, and some may prefer to receive an assessment from a mainstream assessment organisation. The single assessment pathway supports the choice of each older Aboriginal and Torres Strait Islander person.

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

- This should be recorded when registering a client in the My Aged Care system
- It may also be recorded by an assessor during an assessment.
- The preference will then display in the client details as well as on the client's card.
- If one is available, Aboriginal and Torres Strait Islander assessment organisations will be represented with a prefix "FNAO-" and appear at the top of the list of

available services. If none is available in the region, then no organisation on the list will have the prefix.
- Team Leaders will get a warning when they try to transfer if the client has indicated a preference, if the assessment organisation is not an Aboriginal and Torres Strait Islander assessment organisation.
- Sometimes, the older person will want to know the name of the available organisation(s) before being referred to them.

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

Note:

Aboriginal and Torres Strait Islander assessment organisations have commenced in some parts of Australia from August 2025.

In some regions while services are being established, an older Aboriginal and Torres Strait Islander person will not be able to be referred to an Aboriginal and Torres Strait Islander Assessment Organisation. Information about an older person's preference will be used to collect data on the demand for these services. Once Aboriginal and Torres Strait Islander Assessment Organisations become available, this preference information will be used to refer older people to these services if an assessment or Support Plan Review is needed.

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

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

If an Aboriginal and Torres Strait Islander client is already booked in with a mainstream Single Assessment System organisation, and an Aboriginal and Torres Strait Islander assessment service has recently become available in their area; the client should be advised of this option. They should be informed that choosing to be transferred to an Aboriginal and Torres Strait Islander assessment organisation may result in a longer wait time for an assessment. There will also be opportunities for the client to be transferred to the new organisation if their needs change in the future. The client's condition needs to be taken into consideration, that their health condition and care needs would not be adversely impacted by a delay in assessment if they were to be referred to another organisation. Unless the client opts to be transferred, the assessment should continue as planned.

Any preferences for Aboriginal and Torres Strait Islander assessment organisations should be uncovered during the assessor's pre-assessment planning. This allows the assessor time to organise transferring the client prior to the assessment if needed. If this referral is cancelled by the assessor at the point of assessment, this may slow down the assessment process for the client which is not the desired outcome.

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

If the client's preference is to be assessed by the Aboriginal and Torres Strait Islander assessment organisation, the assessor can manage the referral according to the processes detailed in this Chapter.

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

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

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

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

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

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

OPTION B: If there is a FNAO preference captured in the preference field. Sharon notes the preference for an Aboriginal and Torres Strait Islander assessment organisation and knows that there is not one available. Sharon understands that this would have been explained to Violet at the point of triage. Sharon continues with the assessment as planned without asking Violet to unnecessarily confirm her preference multiple times.

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

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

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

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

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

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

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

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

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

Best practice for the client is that Steve supports the client’s choice and his organisation makes contact with the Aboriginal and Torres Strait Islander assessment organisation in the region to ensure that they have capacity, and support a warm handover to transfer Bill.

During the scale up of services, it is important that assessors and assessment organisations stay up to date on which Aboriginal and Torres Strait Islander assessment organisations become available and where. To support this awareness:

- The department will provide updates in the monthly Aged Care Assessment Update newsletter at the end of each month.
- As services roll out, Aboriginal and Torres Strait assessment organisation outlets will be prefixed with “FNAO-” and appear at the top of the list of available organisations.
- Aboriginal and Torres Strait Islander assessment organisations are listed on the interactive map of available services.
- The Department’s website will be updated regularly.

4.3.4. Unlikely to be eligible for an assessment flag

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

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

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

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

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

Note:

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

4.3.5. End-of-Life pathway flag

Assessors can undertake High Priority Assessments for new End-of-Life clients. The IAT will include system capability for team leaders and triage delegates to flag clients as an 'End-of-life client' through the High Priority assessment process. The aged care assessment referral will be flagged as an 'End-of-Life referral' and will be given a high priority.

Team Leaders and assessors will be able to filter for End-of-Life clients.

The End-of-Life Pathway Form does not need to be attached to the client's record for the assessment to proceed. If an End-of-Life Pathway Form has not been submitted, the team leader or triage delegate should advise the older person of the steps required (e.g. downloading the form and/or visiting their GP or nurse practitioner to have the form signed).

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

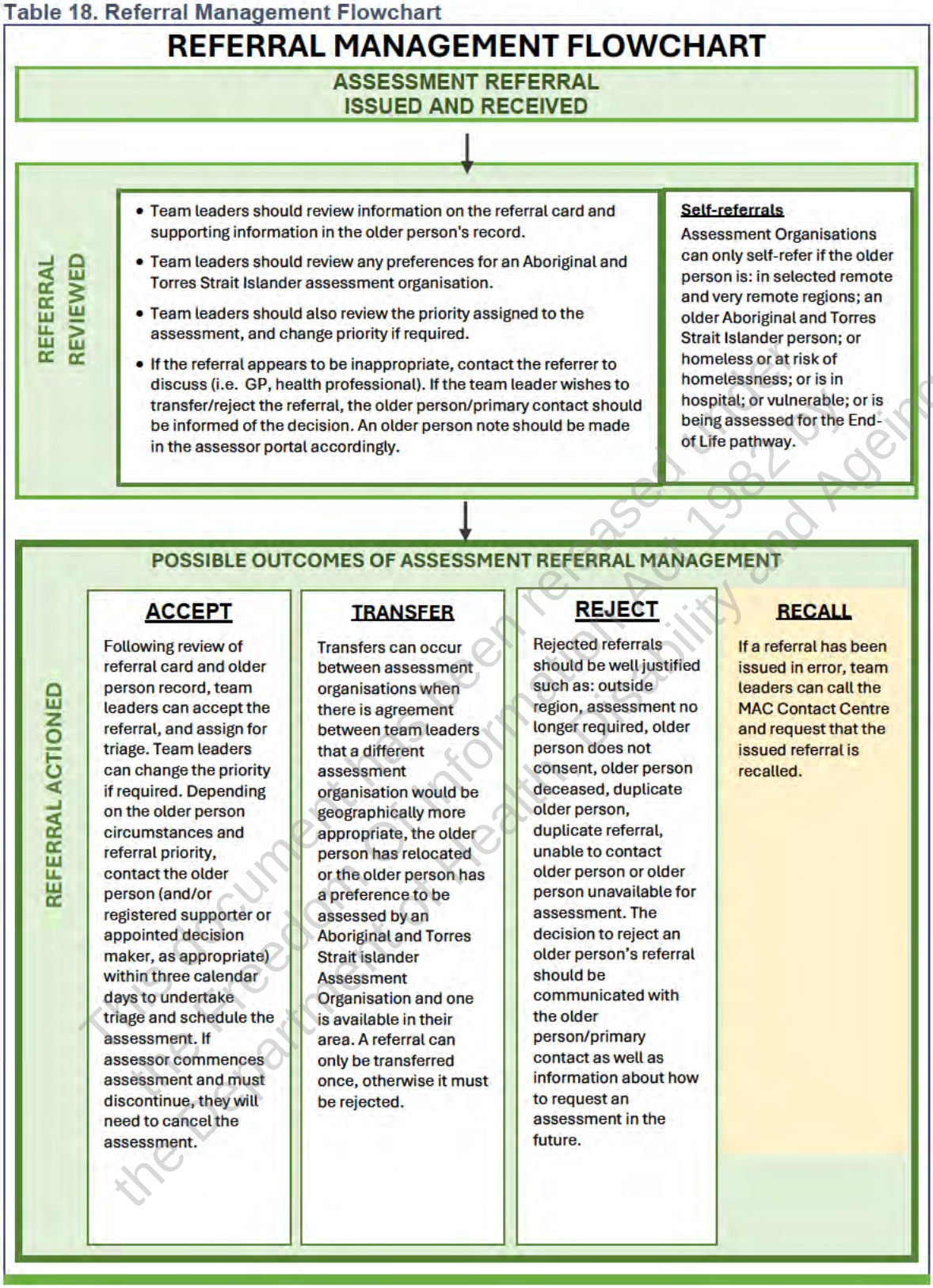
Table 17. End of Life Form verification options

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

Note:

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

Table 18. Referral Management Flowchart



4.3.6. Accept a referral

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

A Team Leader must:

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

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

- Older people and/or their registered supporters should be contacted and eligibility determined through triage within three calendar days of accepting the referral.
- Note that assessors should consider workload management between focusing on SPRs versus reassessments to ensure priority is given to older people with the greatest need.

4.3.7. Transferring referrals

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

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

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

4.3.8. Rejecting a referral

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

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

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

Table 19. Referral rejection - List of values

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

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

Note:

The department monitors the rejected referral rates and rejection reasons.

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

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

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

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

- The older person prefers an Aboriginal and Torres Strait Islander Assessment Organisation where one is not available, and after discussing the risks of waiting; would prefer to wait until one is available than proceed with a mainstream assessment organisation.

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

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

Note:

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

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

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

Any preferences should be identified during the assessor's pre-assessment planning, allowing the assessor time to organise the transfer of the older person to another organisation prior to the assessment. If the referral is cancelled by the assessor at the point of assessment, this may slow down the assessment process for the older person, which is not the desired outcome.

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

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

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

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

4.3.9. Recall a referral

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

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

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

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

4.4. Self-referrals

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

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

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

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

When creating the self-referral, assessors are encouraged:

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

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

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

A Triage Delegate must actively supervise triage conducted by an assessor, via phone or video conferencing. The decision whether someone is eligible to undergo an assessment,

remains with the Triage Delegate and should not be made in their absence. If a delegate is not available to supervise triage the assessment should be paused until such time a delegate becomes available. Assessors conducting triage during a self-referred assessment must nominate the supervising Triage Delegate. Triage will be unable to be completed unless a supervising delegate has been nominated.

Note:

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

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

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

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

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

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

4.4.2. Prevention of duplicate records

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

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

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

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

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

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

4.4.3. Verifying the individual's legal name

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

Legal name vs preferred name

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

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

Note:

It is important to keep in mind when verifying an older person's legal and preferred name that in some Aboriginal and Torres Strait Islander traditions or communities, people can change the name they use throughout their life or be known by different names by different people owing to their changing role/status in their community or events such as the death of a person.

This may also be relevant in other cultures. If appropriate and safe to do so, an assessor should explore all names an older person has had in the years they would have been eligible to receive aged care services.

Additional information in name field

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

Special characters

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

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

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

4.5. Support Plan Reviews and reassessments

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

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

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

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

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

For example, an older person approved for ongoing Support at Home Classification 4 who requires a higher classification (e.g. Classification Level 5) due to increased care needs or a change in priority for home care service must undertake a reassessment by an assessor. They will then receive a new approval by an Assessment Delegate.

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

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

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

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

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

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

Further information on SPRs and reassessments see Chapter 10.

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

4.5.1. SPR and reassessment requests

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

A SPR may be requested by:

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

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

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

Note:

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

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

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

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

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

4.5.2. Managing an SPR request

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

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

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

- End-of-Life SPRs, completing them as soon as possible. These will be marked 'urgent' in the system.
- Referrals where referral information indicates a significant event has occurred or the older person has a rapidly deteriorating condition, all of which will likely result

in a reassessment. This will help ensure prompt review by a Triage Delegate, who may recommend interim CHSP services for the individual.

- Requests for **a second unit of restorative care** where there is a need for continuity of services

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

Transfer the request

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

Note:

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

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

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

Recommend a reassessment

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

Cancel the request

Actions if considering cancelling the SPR:

- If there is insufficient information on the SPR request, however clarification is required on certain aspects, the assessor should contact the older person or service provider where possible to clarify the request, prior to progressing a decision to cancel the SPR. This will manage the risk to older people to ensure the older person is not disadvantaged where they require changes to their aged care support.
- The review request may be cancelled by an assessor and a SPR not undertaken if it is inappropriate or if insufficient information is provided to warrant the SPR, or the assessor (after a number of attempts) has not been able to contact the older person's primary contact (who may be the older person, registered supporter, appointed decision maker or agent organisation).

- As a minimum requirement, where the assessor cancels the SPR, they must include the cancellation reason and provide clear explanation justifying the cancellation in the cancellation details field.
- Indicating a clear cancellation reason allows the person making the request to, if necessary, amend and resubmit the request or follow up with the assessor as necessary.
- Where, through the course of the SPR conversation, the older person and/or their supporter considers no changes are required, they may agree that the SPR can be cancelled and withdraw their application. A notice of decision advising on this outcome is not required as the applicant's application is taken to be withdrawn.

Note:

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

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

This is also applicable where the assessor decides to cancel an SPR due to the older person having been recently provided with an SPR and there has been no change in the older person's care needs or situation since the SPR was conducted.

4.6. Deceased older people

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

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

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

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

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

5. Chapter 5: Assessment activities

What you'll find in this chapter

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

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

5.1. Obtaining consent for triage and assessment

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

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

- Triage Delegates or assessors must use the applicable consent script online via the Assessor Portal (or in the app in the case of self-referrals).
- The Triage Delegate or assessor should read out the consent script/s to ensure the older person understands and is informed of the purpose for collecting the information and how it will be used and stored, and who the personal or sensitive information will be collected from (such as contacting a person's GP, other health professionals, disability service coordinator or service provider, family members or carers). If the older person prefers, the older person can read the consent script/s themselves on a printed form.
- For offline assessments the assessor must use a hard copy version of the My Aged Care Assessment Consent Form. This form includes the consent scripts and fields to record the consent for assessment and service referrals. It is located via the *Reports and Documents* tile within the My Aged Care assessor portal.

- While the My Aged Care Assessment Consent Form and scripts should be used to obtain consent from the older Aboriginal and Torres Strait Islander client, assessors should take care to adapt the consent script to ensure that it can be clearly understood.

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

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

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

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

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

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

- The assessor may make an informal assessment of an older person's decision-making ability if the assessor is aware of matters that may suggest that the older person does not have decision-making ability and consequently may not have legal capacity to provide informed consent. If the assessor is satisfied that the older person does not have capacity to consent to the assessment, the assessor cannot continue with the assessment unless the assessor can identify another person who can consent on the older person's behalf.

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

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

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

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

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

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

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

    - indicate the signed form has been uploaded and consent given

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

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

- If a carer is identified for the first time during the assessment under the 'Carer profile' section of the IAT, the assessor must confirm with the older person that the

older person has the carer's consent to provide the carer's telephone number and related personal information.

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

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

Note:

1. If consent cannot be given by the older person or their active, appointed decision maker (either registered as a supporter or not), the triage or assessment cannot proceed, and the referral is rejected.

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

Privacy notice and consent web page

Federal Register of Legislation website: Aged Care Act 2024 - Federal Register of Legislation

The Privacy Act 1988

Healthdirect website: Healthdirect Privacy policy

My Aged Care website: Arranging someone to support you

Privacy Policy | My Aged Care

5.2. Triaging assessments

Triage is performed after the acceptance of a referral and prior to conducting an aged care assessment. Triage is conducted for every accepted referral, generally over the telephone and should occur within three calendar days of accepting a referral. Triage helps ensure that older people with low needs are not over-assessed and that those with complex needs have access to a comprehensive assessment. Triage also aims to validate the outcomes produced at screening, including the priority allocated to the assessment and whether urgent services are required. For participants seeking access to

the End-of-Life Pathway who have submitted their End-of-Life Pathway Form at this stage, triage may also involve verifying this documentation. In addition, the triage process includes scheduling the assessment, work health and safety screening, arrangements for communication needs and confirming support people ahead of the assessment.

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

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

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

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

5.2.1. Delegation to the Triage Delegate

The Triage Delegate has powers and functions afforded to the System Governor under the Act delegated to them. Section 58 of the Act relates to eligibility for an aged care needs assessment.

Within an assessment organisation, the person holding a Triage Delegate role must meet certain qualification (detailed in Appendix G) and training requirements (detailed in the Learning Strategy).

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

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

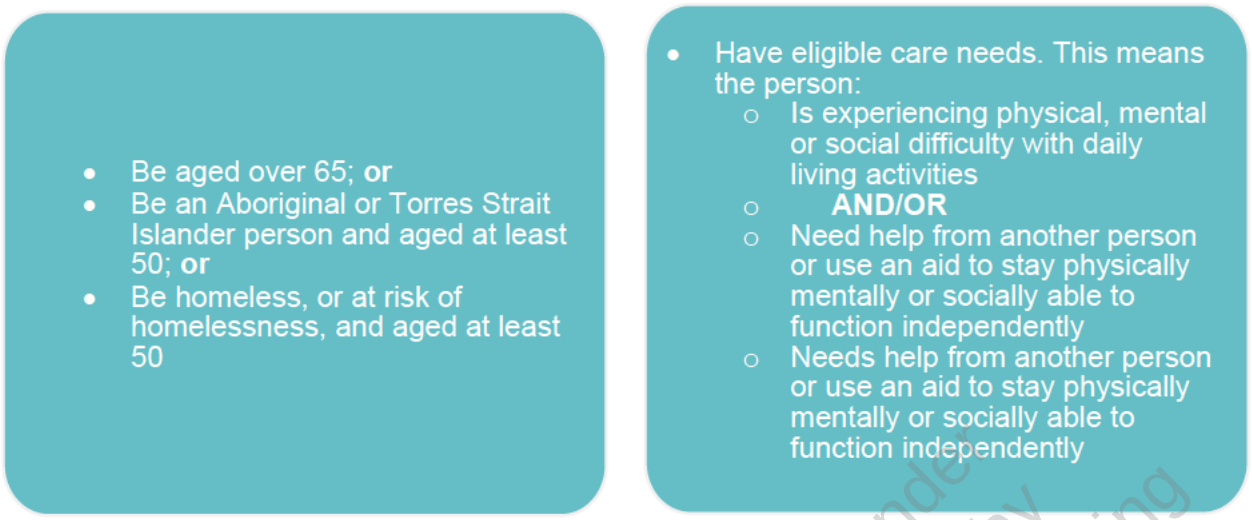


Figure 1 - Eligibility requirements

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

- the older person's date of birth, by checking with the older person, their registered supporter and/or active, appointed decision maker
- that the older person has declared they have care needs, noting this can be made by the older person through the registration and screening process or through a written statement from a person applying on the older person's behalf, or through written medical records (see section 58-5 of the *Aged Care Rules 2025*)

for older people who have already been assessed at least once, the older person has had a significant change in circumstances and a reassessment is required. Significant changes are provided for in the *Aged Care Rules 2025* and include:

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

Eligibility considerations for older Aboriginal and Torres Strait Islander people

The assessment process for Aboriginal and Torres Strait Islander people between 50-64 years of age is the same process for assessing people aged 65 years and older. Under the *Aged Care Act 2024*, triage delegates will be required to inform people who are under 65 and seeking aged care services of alternative services that may meet their needs, prior to determining their eligibility.

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

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

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

If a person has gone through the screening process and been advised they are likely to be ineligible for the needs assessment, a flag will appear in the My Aged Care Assessor Portal. Triage Delegates should use all available information from screening, on the older person's My Aged Care Profile and provided during triage to reach their own decision regarding an individual's eligibility. Triage Delegates are ultimately responsible to make a decision about an older person's eligibility for a needs assessment.

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

Under the Instrument of Delegation, Triage Delegates will also be delegated the power to decide under section 64 of the *Aged Care Act 2024* that an older person has undergone a significant change of circumstances or other change in their circumstances and requires a reassessment of their needs. The information required by Triage Delegates to confirm a reassessment will be gathered by assessors during a support plan review. During the November 2025 transition, Triage Delegates should pay special attention to any clients that are marked as unlikely to be eligible due to their age and check if their application for care was already in-progress before 1 November 2025. See section 1.5.11*Younger people* in Chapter 1.

5.2.2. Informing the eligible younger person of other services

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

Note:

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

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

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

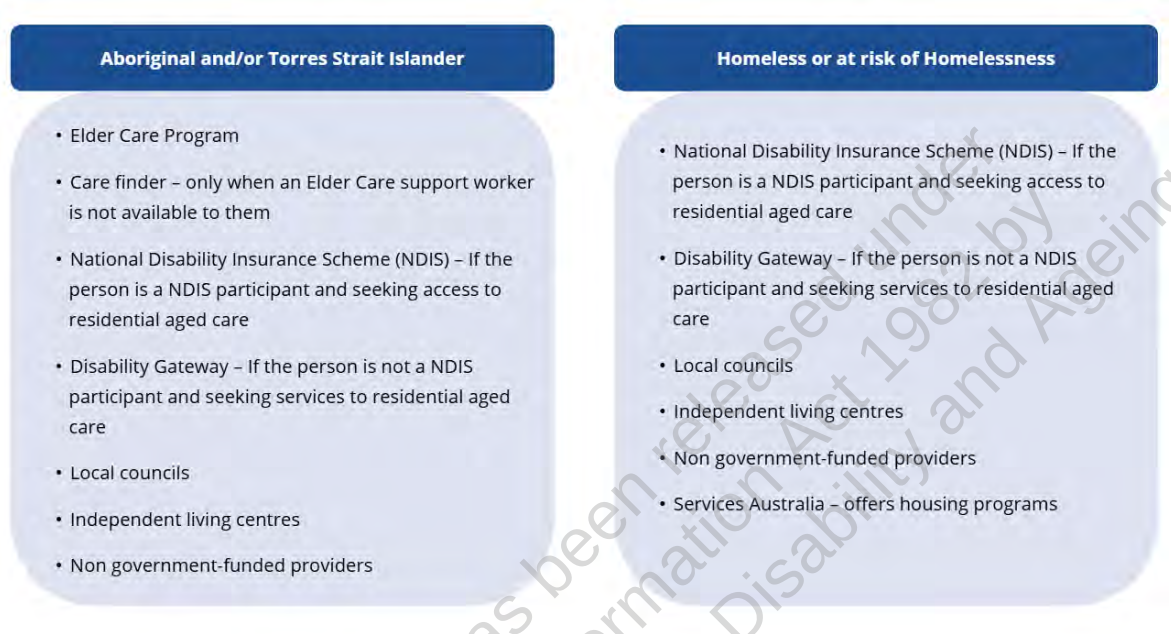


Figure 3 – list of alternative options for the eligible younger person to consider

5.3. Conducting triage

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

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

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

Note:

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

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

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

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

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

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

- Help from a care finder | My Aged Care

5.3.1. Initial discussion

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

- Identify who you are and the organisation you are from and confirm that they have 15 to 20 minutes to discuss their assessment request.
- Complete an identity check and confirm whether there is anyone else with the older person at the time (e.g., registered supporters). If they do not have anyone with them and would like someone with them, call back at a more suitable time.
- Advice you have received the referral, who it is from and the role your organisation plays.
- Advise you will be asking a few questions relating to their general health and wellbeing to help inform assessment needs.
- Confirm consent (consistent with section 5.1) and ensure the older person understands why they are having the assessment, why the assessor needs to come to their home (if applicable) and allay any concerns or fears that they may have about the assessment. Should the older person or their active, appointed decision maker choose not to give consent, the triage process is to end and the assessment referral is rejected.
- Confirm their preference for an Aboriginal and Torres Strait Islander assessment organisation (see below this section for further detail)
- Check the contact information for the older person, and if appropriate, the contact information for the registered supporter or agent, such as a care finder (including address for receiving correspondence) to ensure it is complete, correct and validated.
- Gather any additional information required, including whether the older person would like someone who supports them/registered supporter/agent present for the triage questions asked using the Integrated Assessment Tool or at the assessment.
    - If an older person lacks decision-making capacity, an active, appointed decision maker (whether or not a registered supporter) must be involved in the assessment to ensure the older person is accurately assessed. An active, appointed decision maker for this purpose may already be identified on the older person's record as a person to whom all correspondence must be sent. Triage Delegates should review the proof an appointed decision maker has provided to the System Governor to support their authority. Registered supporters who are not active, appointed decision makers can also be involved, in line with the will and preferences of the older person. The assessor can submit a request to create a new registered supporter/agent relationship if required (see Chapter 3).
    - Submitting a 'request' may mean a supporter relationship is recorded in the system as a pending relationship seeking to be registered by the System Governor. There are many ways to submit a request, including with the help of an assessor, online, by calling My Aged Care, or using a printed registration form. More information on the registration pathways will be available from 1 November at: www.myagedcare.gov.au/registering-supporter.
    - A person who is seeking to become a registered supporter who is also an active, appointed decision maker must provide proof to show they are an active, appointed decision maker for the older person. This is likely to be legal documentation. Medical evidence may also be required to establish the older person's loss of decision-making capacity.
- Organise an interpreter if required (e.g., for interpreting services or Auslan) and ensure other necessary supports are in place for the assessment.

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

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

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

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

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

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

- When a triage delegate receives a referral, they should view the client information to gain a preliminary understanding of the client's situation.
- If there is no preference listed, please record the preference after having a conversation with the older person.
  - It is important to have a conversation with the older person about their preference. It should not be assumed that all Aboriginal and Torres Strait Islander people will want their assessment with an Aboriginal and Torres Strait Islander assessment organisation.
- The client's preference will determine whether the referral is accepted, transferred or rejected.
- If a transfer is required, this will need to be managed with the support of a Team Leader.
- It will also ensure that the assessment process is responsive to the person's individual situation.

Asking triage questions using the Integrated Assessment Tool

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

online induction training and triage delegate training before undertaking the triage component of the IAT.

See the IAT User Guide for further information.

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

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

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

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

Note:

For referrals for the End-of-Life Pathway, triage questions will be optional so there is flexibility to only ask questions that are appropriate to the individual.

When completing the Triage section of the IAT, the triage delegate must provide clear justification in the 'Outcome/advice for assessment notes' field to support the recommended assessment type. This justification should explain why the selected assessment type is appropriate.

At the conclusion of the triage component of the IAT, triage delegates will confirm eligibility for an assessment, the assessment type, assessment priority and whether urgent services and/or linking supports are required, in instances where these services were not provided at screening. In the case of End-of-Life Pathway referrals, if an End-of-Life Pathway Form has not already been submitted, the triage delegate should advise the older person of the steps required (e.g. downloading the form and/or visiting their GP or nurse practitioner to have the form signed).

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

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

Note:

If the older person is deemed to be ineligible for a needs assessment, the Triage Delegate should communicate the decision and inform them how to request an assessment in the future (this can occur at a separate time to the initial phone call, if necessary).

Effective communication with the older person (and their active, appointed decision maker or registered supporter, where appropriate) on a decision to not recommend an assessment, and effective communication between assessors, assists with managing expectations and reducing complaints.

An 'Ineligible for Assessment Letter' will need to be sent to the older person (and registered supporters, as required under the Act) as notice of this decision.

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

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

5.3.2. Referring for urgent services and linking support at triage

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

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

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

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

5.3.3. Triage for clients who have been referred through a Support Plan Review

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

- Where a conversation with the client has already occurred, the Triage Delegate should consider the conversation summary provided by the assessor as necessary.
- If satisfied, the Triage Delegate should complete the triage questions of the IAT, without needing to speak with the client, given this occurred at the SPR stage. An assessment can then be scheduled for the client at a time that aligns with their priority setting.

Note: That consent to complete IAT Triage questions should be sought by the assessor when the assessor is speaking with the client (or their registered supporter and/or appointed decision maker) at the SPR stage.

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

Fact sheet for Assessors and Triage Delegates on Support Plan Reviews that initiate a new assessment | Australian Government Department of Health, Disability and Ageing

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

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

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

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

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

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

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

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

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

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

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

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

To access the End-of-Life Pathway, existing Support at Home participants can request a urgent Support Plan Review.

5.3.5. In-hospital triage and self-referrals

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

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

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

When determining whether an individual aged 50-64 years is eligible for an aged care needs assessment, triage delegates should clearly record their decision and the information they relied upon to come to that decision. This should be recorded in the free text box at the end of the IAT triage section. For example, when finding someone aged between 50-64 is eligible for an assessment under the homeless/risk of homelessness provisions of the Act, the triage delegate should make specific reference to which criteria under the relevant definition applies to the individual who is seeking an assessment. Refer to section 1.2 of this Manual for the definition of homeless and risk of homelessness.

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

Note:

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

5.3.7. Preparing an older person for their assessment

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

Additionally, triage delegates should:

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

Note:

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

- Upload any additional older person information to the older person record (e.g., WHS screen) and use 'Notes' to record assessment booking details. Include if relevant, with older person's consent, sensitive information in sensitive notes and attachments.

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

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

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

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

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

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

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

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

Department of Health, Disability and Ageing website:

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

Fact sheet for Assessors on care finders

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

Help from a care finder

Department of Home Affairs website: Translating and Interpreting Service

5.4. Revoking eligibility during an assessment

Under the *Aged Care Act 2024* there are clear age eligibility requirements to have an aged care needs assessment. See Eligibility requirements to access government funded aged care services in Chapter 1.

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

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

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

5.5. Assessment settings

5.5.1. Usual accommodation setting

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

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

5.5.2. Telehealth

It is best practice for assessments to be conducted face-to-face. Assessment organisations are strongly encouraged to ensure assessments are face-to-face wherever possible. Where face-to-face contact between the assessor and older person is not possible (e.g., when assessing an older person in a remote area or the older person is inaccessible due to exceptional circumstances such as a seasonal weather event), a telehealth assessment may be undertaken. The assessor must make additional efforts to ensure the quality of assessment is not compromised when conducting a telehealth assessment and that assessment decisions remain evidence based.

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

5.5.3. Remote setting

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

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

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

5.5.4. Hospital setting

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

For those older people in hospital requiring an assessment, they should be assessed in the same way as those assessed at home, utilising the IAT to ensure a nationally consistent approach to assessment of aged care needs, including consideration of the home environment and social issues. An older person needs to be in a stable condition for a hospital-based assessment to take place (unless a rapidly deteriorating condition makes this impossible). Being medically stable ensures that the care needs of the older person outside of the hospital can be accurately assessed and the most appropriate care services recommended.

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

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

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

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

5.6. Commencing the Assessment

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

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

approach during the assessment. This will allow the assessor to develop rapport with the older person and their support network.

- Download the assessment if using Aged Care Assessor App.
- Check whether a supporter or agent for the older person has been registered or established. If the client is already registered in My Aged Care, assessors can do this by using the assessor portal to find the client, then view their support network (if any supporter relationships have been registered). Refer to Chapter 3 for information on how registered supporters must engage with the older people they support, and how they might be involved in an assessment.
- Check the authority of any active, appointed decision makers of the older person, if they have made themselves known to the assessor or My Aged Care. Appointed decision makers are not required to register as supporters to exercise their legal authority under a Commonwealth, state or territory arrangement. However, this is encouraged to streamline authentication and information sharing to support older people. Assessors can engage with active, appointed decision makers before, or without them, formally registering as supporters, provided the assessor is satisfied they are acting within their authority. To do so, assessors should seek legal documentation that shows the person is an active, appointed decision-maker for the older person and that their decision-making authority is relevant to the assessment. Medical evidence about the older person may also be required to show that the decision maker's authority is active.
- Review notes entered at triage including referrals, attached documents and previous support plans if applicable, to help familiarise yourself with the older person and their needs and limit the need for the older person to repeat their story.
- Connect with the local Aboriginal and Torres strait Islander community with their knowledge of local services and culture.

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

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

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

- This must occur **prior to the assessment**. Once the assessor starts the assessment, it will need to be cancelled it they are not proceeding with the assessment. The general recommendation would be that the assessor with the booking continues with the assessment as planned, **with the agreement of the client.**
- The client's **condition needs to be taken into consideration**, that their health condition and care needs would not be adversely impacted by a delay in assessment if they were to be referred to another organisation.
- A conversation with the client **prior to the assessment** is recommended to ensure that they have choice and control and the ability to make decisions regarding their care.

- If the client's preference is to be assessed by the Aboriginal and Torres Strait Islander assessment organisation; and they understand the timing impacts; then the assessor can ensure a warm referral as per the processes in the My Aged Care assessor manual.
- A new rejection reason 'client prefers a FNAO' is available in the IT system. An older Aboriginal and Torres Strait Islander person should not be rejected based on a client's preference unless it is a last resort. A transfer prior to the assessment is preferable to a rejection.
- If the referral is cancelled by the assessor at the point of assessment, this may slow down the process for the client which is not the desired outcome.

This above process also applies to Support Plan Reviews, and subsequent new assessments.

At the time of the assessment, the assessor must:

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

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

5.6.2. Wallet check

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

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

Note:

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

5.6.3. Registering a supporter

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

The registered supporter role will replace existing regular and authorised representative relationships in My Aged Care. Older people with regular and authorised representative relationships active in My Aged Care on 31 October 2025, who did not opt out, will move into supporter relationships on 1 November 2025. If the older person or their supporters did not want to transition to a supporter relationship and did not opt out by 31 October, they can still request to end their supporter relationship at any time from 1 November 2025 in their Online Account or by calling My Aged Care.

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

- completing the Registration of a Supporter form. The assessor can upload the form and any associated documentation to the client's record. **Note:** a registration form may also be generated following the completion on the online registration form through the My Aged Care website. This will look different to the Registration of a Supporter form but should have all the same information. Assessors should treat it the same as the Registration of a Supporter form.
- submitting a registration request online with the assessor via the assessor portal or app, including uploading any associated documentation. If necessary, the Aged Care Assessor App camera can take a photo of the document to upload as an attachment as long as the document photographs are clear and readable.

A completed registration form and any associated documentation can be uploaded to the client's record. The prospective supporter can also mail a copy of the documents to the My Aged Care contact centre, and the assessor can write a note in the older person's record of this undertaking (see Appendix C. Contact Details).

Note:

Updated consent scripting and declarations for the registration of a supporter must be used by assessors if they are assisting an older person or prospective supporter through the registration process. These will be available on the Assessor Portal or App, and the printed registration form from 1 November 2025.

It is important to note that while assessors can collect and submit the required information, they may not be able to confirm or approve the registration of a supporter relationship, depending on the circumstances. For example, some applications must be escalated to the departmental team responsible for supporters to consider before a decision to register can be made. This includes applications:

- where the prospective supporter has declared a conflict of interest
- where there is anything to suggest the prospective supporter cannot comply with the duties of a supporter (e.g., the prospective supporter had a previous registered supporter relationship cancelled), or
- where the prospective supporter is also an appointed decision maker and must provide additional documentation like legal and medical evidence.

From 1 November 2025, the My Aged Care website will include information on the various ways a person can request to register, or become, a supporter. You can access this information at www.myagedcare.gov.au/registering-supporter.

If, in submitting a request to register a supporter who is also an appointed decision maker for the older person, proof of legal decision-making authority cannot be obtained, advise the pending registered supporter to provide the required proof, including any legal or medical documentation to the delegate team responsible for registered supporters. This team will process the documents and if validated, register the relationship.

5.7. Undertaking an assessment using the Integrated Assessment Tool

The assessment starts with getting the older person's consent. Consent from the older person, or their active, appointed decision maker is recorded on the IAT.

The IAT is an assessment tool that has been designed to support skilled assessors to determine a client's aged care needs. It comprises questions across social, physical, medical, cognitive, and psychological domains as well as home and personal safety, risk of vulnerability and support considerations.

The assessment component of the IAT is divided into twelve sections. Some sections of the IAT contain nested questions to tailor assessments, only diving deeper into areas where needed. This means that some question sets or validated tools in the IAT will only display to the assessor if certain answers are selected to the question directly proceeding

it. The IAT integrates eleven validated tools directly into the assessment process, enhancing the depth and clinical relevance of the assessment.

Assessors may wish to use assessment tools not included in the Validated Assessment Tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation. Each assessment organisation is responsible for providing their assessment staff with training on how to use these tools. General information about each tool is provided in assessor induction training but additional training is recommended to make sure each assessor understands the results from each validated tool.

The IAT includes decision support rules to assist assessors to make recommendations for the type of support an older person requires based on the older person's responses to relevant questions.

In completing the IAT, the assessment information should include:

- evidence that the assessor has explored the older person's own supports and/or non-funded services (e.g., state and local government programs, private services) as options to help maintain their independence.
- evidence of supporting an older person's communication or support person needs.
- a completed 'Support Considerations' section to demonstrate an understanding of what is important for the older person in regard to how support is provided, such as the below list (note some of these may be sensitive topics):
    - any cultural and/or religious values and beliefs
    - gender identity or sexual orientation/sexuality or experience of discrimination
    - history of childhood experiences
    - Life experiences including traumatic events and associated triggers
    - other relevant information relating to parole conditions or other information that should be sensitively discussed with the older person when developing the Support Plan and that providers should be aware of.

The IAT User Guide provides assessors with further advice about each question in the IAT and possible answers. Assessors must refer to the IAT User Guide to ensure accuracy in the use of the IAT and in the delivery of high-quality assessments.

All mandatory questions must be completed, and it is best practice that the older person's concerns and goals are added before finalising the IAT. The assessor then selects 'Finalise IAT' before moving to the support plan. This is so the system can recommend a home support classification (also referred to as a classification level under the Act), which may be a Support at Home classification or CHSP. Note that a classification level recommendation must be made for people who choose to access services through the MPSP or NATISFACP.

If the IAT has not been finalised, the IAT outcome and classifications will not be displayed. The assessor will not be able to recommend the person for funded aged care services.

Aboriginal and Torres Strait Islander assessment organisations will be required to use the IAT to conduct assessments and must do so in a way that is culturally safe for the region or older person. Assessors may conduct the assessment without a device. In such cases, the assessor should upload the information into the IAT when the assessment is completed. Assessors may also be able to make inferences from the yarn to complete the IAT.

Use the validated culturally appropriate assessment tools as needed (see the IAT User Guide for more information).

Note:

For End-of-Life Pathway assessments, only mandatory questions that are required to run the IAT Outcome and generate a classification are required to be completed. This is to ensure the older person has a valid classification to return to if they need services beyond the End-of-Life Pathway funding period. Other questions are optional based on the individual's needs and context.

Important:

Under Support at Home, individuals who are care leavers are eligible for a care management supplement which will be credited to their provider's care management account.

To identify individuals who are eligible for a care management supplement during the assessment, assessors must use the diversity fields in the IAT, which do not currently capture care leavers.

Assessors who have identified individuals who are care leavers during the assessment should select the diversity field 'a person separated from your parents or children by forced adoption or removal'.

This will ensure Services Australia is able to identify these individuals from the assessment and apply a care management supplement to their provider's care management account. Refer to the Support at Home Program Manual for more information on care management supplements

IAT User Guide

5.7.1. Clinical attendance

All sections of the IAT will be visible to both clinical and non-clinical assessors.

Where an assessment is initiated as a home support assessment by a non-clinical assessor and questions are triggered that require clinical judgement (referred to as clinical questions), the non-clinical assessor must arrange for the attendance of a clinical assessor to be involved in asking the clinical questions in the IAT. This process is known as clinical attendance and is supported by an assessment organisation's Clinical Governance Framework (see Appendix D for guidance) and standard operating procedures. This process helps to make it easier for an older person to have their needs fully assessed without delaying their assessment or having to be transferred between assessors. The clinical attendance process is outlined in detail below.

Clinical attendance in practice

When a non-clinical assessor triggers clinical questions in the IAT, a warning message in the My Aged Care Assessor Portal or Aged Care Assessor App will prompt the assessor to complete the section in accordance with their organisation's clinical governance framework. If the assessor is using the IAT offline form, the clinical questions are colour coded in light pink.

Where clinical questions are triggered, the assessor must seek clinical attendance to ask the clinical questions (listed at Appendix E). Clinical attendance will need to be sought from a staff member who is assigned a clinical assessor role in the My Aged Care Assessor Portal. The ways in which clinical attendance can occur are detailed in the Table below and presented as tiers. Tier 1 is considered best practice; it is expected that an assessment organisation will adopt Tier 1 clinical attendance in the majority of cases.

Note:

Enrolled Nurses (EN) who hold the clinical assessor role cannot provide clinical attendance to non-clinical assessors. This is considered outside an EN's scope of practice.

For case studies of how clinical attendance will work in practice please see Appendix E.

Table 20. Clinical attendance procedure

Tier 1	A clinical assessor who holds a clinical assessor role in the My Aged Care Assessor Portal is available by video or phone call at the time the assessment is taking place to be involved in asking the clinical questions with the non-clinical assessor to the older person being assessed. A video call is preferable. The assessor can receive a call back when a clinical assessor becomes available. The assessment should continue while waiting for the callback. In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of any other clinical questions (see appendix E) and ensure that these questions are answered with a clinical assessor in attendance. There may be situations where it is not appropriate for the assessor to continue with the assessment, even with virtual, clinical attendance. This will be determined using the following criteria:

- It is not physically or psychologically safe for the older person to continue the assessment,
- It is not physically or psychologically safe for the assessor to continue the assessment,
- The older person's condition requires a clinical assessor to undertake an end-to-end assessment

Where it is considered inappropriate to continue, the assessment will end and a team leader will reassign the incomplete assessment to a clinical assessor to undertake.

Tier 2

There may be circumstances where real-time clinical attendance is not possible. If a clinical assessor cannot be contacted at the time the assessment is taking place, the assessor will complete the questions that do not require clinical judgement. All other clinical questions are noted and cannot be asked.

In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of the clinical questions prompted (see appendix E) and ensure that these questions are answered with a clinical assessor in attendance.

The assessment will end once the assessor has completed the non-clinical questions in the IAT (noting the IAT itself will remain incomplete). The assessor will need to speak with a clinical assessor in their organisation about the assessment and the clinical questions.

If it is appropriate for the clinical questions to be asked by a clinical assessor over the phone, arrangements will be made with the older person and relevant support people for this to take place. It is preferable the original, non-clinical assessor is also on the call. If the clinical components are completed over the phone by a clinical assessor, the assessment does not need to be reassigned to this assessor.

It may be determined that the assessment should be reassigned to a clinical assessor to complete the assessment, either in person or over the phone. This may be required because:

- multiple clinical questions are triggered in the IAT,

- the needs of the older person are best assessed in person to ensure a high-quality assessment.

Where an in-person assessment with a clinical assessor is required, a team leader will reassign the assessment to a clinical assessor.

If the clinical process is initiated the assessor must:

- ensure the older person understands that there are questions in the assessment tool that need to be asked with a clinically qualified assessor so that they can apply clinical knowledge and judgment to ensure that the older person's needs are assessed in full and with their safety and wellbeing in mind. This should occur before the clinical assessor is contacted.
- include the older person in the initial discussion when the clinical assessor is being briefed on the older person's situation. The older person and/or their support person should be given the opportunity to describe their circumstances if they feel comfortable to do so.
- ensure the camera is on at both ends so that older person can see the clinical assessor if the clinical assessor is called in on a video enabled device.
- ensure the call is on speaker phone so that the older person and clinical assessor can speak directly to one another, if the clinical assessor is called on a phone without video functionality.
- explain to the older person that a follow-up phone call will be necessary to complete their assessment, if real-time clinical attendance is not possible.

If a follow-up call is necessary:

- the original non-clinical assessor should be present on the phone call to ensure there is continuity of contact with the original assessor.
- it is important that the non-clinical assessor keeps the older person, their primary contact and/or support person up to date on when the follow up phone call will take place.

5.7.2. Tools and techniques for assessing an older person's needs

The table below details best practice tools and techniques for undertaking aged care needs assessments.

Table 21. Aged care needs assessment best practice tools and techniques

Use the Aged Care Assessment Quality Framework	• Use the four quality goals, personal, effective, connected and safe in your assessment practice.
Use a conversational approach when	• Use a conversational approach when asking questions, rather than simply running through the assessment questions and ticking boxes. Ensure your conversation is undertaken in a manner that is respectful, non-judgmental, and non-confrontational.

interacting with the older person	• Know when and how to best use closed, open, direct, and indirect questioning. • Use motivational interviewing techniques such as expressing empathy and eliciting self-motivational statements. • Use active listening skills. • Make eye contact to help engage the older person in the assessment process, unless it is culturally inappropriate to do so. For example, some Aboriginal and Torres Strait Islander people may consider direct eye contacts disrespectful or uncomfortable, but others may be more comfortable with Western norms of communicationIf using a computer at the older person's home, ensure you are not focused on just the computer. • Gauge the older person's level of engagement in the assessment. Look for signs of fatigue or discomfort and adjust approach accordingly. For Aboriginal and Torres Strait Islander clients • observe the local cultures and customs when conducting the assessment. • start with a social yarn to build rapport and trust. Share stories or other topics of common interest. • Take a whole-of-person approach to the discussion – understanding what motivates a person and contributes to their wellbeing – spiritual, emotional, and physical. • Explain to the client that if they feel uncomfortable during the assessment, it will be paused and rescheduled to ensure their wellbeing. Allow for multiple visits, if required, to build trust and develop a relationship between the assessor and the older person • welcome the presence of the older person's family member or advocate to be part of the meetings • take a less formal, yarning approach to aged care assessment.
Use appropriate language when speaking with the older person	• Use needs-focused language, explaining what could be short-term vs. long-term options to meet their needs. • Use language that is positive and not dismissive. If necessary, potentially sensitive topics (such as lack of service availability or older person fees) can be introduced at the appropriate place during the assessment process after the older person's areas of concern and goals have been identified, and when support options are being explored in the Support Plan stage. • Use language that focuses on the older person's strengths, abilities and what they want to achieve and how these could be further supported – a focus on independence. • Take the time to explain what will happen • Use informal and the local language where possible and avoid jargon • Adjust language as needed to ensure sensitivity towards End-of-Life Pathway participants (for example, focusing on more immediate needs rather than longer-term goals).

	• Reflect the conversation back to the older person to ensure you have understood what was said and agreed on.
Interpreters or support person	• where the older person prefers to communicate in a language other than English or has indicated in their record that a support person is required, an interpreter or support person must attend the assessment (either in-person or via phone).
Supporting people with dementia and other cognitive impairments	• Use simplified language where appropriate. • Repeat questions and information where needed • Be attuned to non-verbal signs that the person may need further information to help them understand. • Seek discrete responses to questions (e.g. 'Yes' or 'No', or choices between two options) rather than multiple options. • Provide ample time for a person to respond to questions.
Using Validated Assessment Tools	Assessors may wish to use assessment tools not included in the Validated Assessment tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation. Clinical assessors should use their clinical judgement to determine if it is appropriate to use other Validated Assessment Tools. If other tools are used, the assessor should make a note of this in their assessment summary.
Observing functional activities	Where possible, assessors must observe the older person's activities to gain insight beyond information that is conveyed just verbally by the older person, a registered supporter or anyone else who supports the older person. Therefore, collect information through additional means: • ask the older person to ***show you*** how tasks are completed in the home and ***observe*** the older person undertaking those tasks (this is an 'active' assessment) and • advise the older person ***what*** you have observed/seen during the task.

5.7.3. Aboriginal and Torres Strait Islander assessments

Older Aboriginal and Torres Strait Islander people have strongly indicated long wait times for an assessment are a significant concern. To support timely access to services, assessors are encouraged to use their professional judgement to determine when an

assessment can be completed in one session or, be split over a few sessions without disadvantaging the client from receiving timely services.

By starting the assessment with a yarn, the assessor should be able to gauge whether it is appropriate to proceed with completing the assessment during the session.

Where an assessment cannot be finalised during the initial session and additional sittings are required, the assessors should complete the initial yarn and schedule a follow up assessment. The subsequent sessions should be conducted as soon as practicable, as service referrals cannot proceed until the assessment is completed, and in the case of comprehensive assessments, the Support Plan has been approved by the Delegate.

While the assessment remains open, the assessment organisation is required to maintain regular check ins with the client to ensure their circumstances have not changed. This ongoing engagement helps ensure the assessment remains accurate and responsive to the older person's needs.

Factors to consider in determining whether to complete the assessment tool on the first visit include:

- **Support from Elder Care Support worker**: Has an Elder Care Support worker facilitated the older person's entry into the aged care system, explained the assessment process, and help built trust in engaging with aged care?
- **Client Engagement and Readiness:** Are the client's body language and verbal cues non-responsive, suggesting they need more time to become familiar with the concept of aged care assessments?
- **Availability of Information:** Has sufficient information been collected from various sources to allow assessment to be undertaken in one sitting?
- **Supportive Environment:** Are family and/or community members present and helping to create a safe and non-stressful environment for the assessment?

If an assessor determines that an assessment should be conducted over multiple sittings, the assessor should conclude the yarning session within a reasonable timeframe.

5.7.4. Assessors referring clients for urgent CHSP services

Note:

Information collected through the IAT to that point will be lost once the assessment is cancelled, so the IAT assessment conducted so far should be printed out from the "client's assessment history" tab prior to cancelling the assessment. A new "high priority" assessment can then be self-referred for the client.

If the assessor identifies, at a check in that the older person's circumstances have changed and there is a significant risk of harm if aged care services are not provided to the person immediately, the assessor may cancel the assessment and refer the person for urgent services.

5.7.5. Recording assessment information

Assessors should make sure all important assessment information is recorded before leaving the assessment. The assessment information in the IAT should be transparent, objective, accurate, complete and in plain language.

Before an assessment is finalised, assessors should perform a quality check on the assessment information, expanding on information and assessment evidence where required. Accurate recording of assessment information prevents unnecessary follow-up queries and makes it more easily readable and usable for people who need to access it in the future. Once the IAT is finalised, it will become read-only and cannot be edited.

The accurate recording of assessment information (see the Aged Care Assessment Quality Framework):

- lays the foundation for creating the Support Plan for the older person and is reflective of what the older person actually said, showed or was observed doing
- minimises duplication between the assessment and Support Plan
- provides sufficient evidence for assessment delegate decision
- is required for audit purposes
- helps to inform an older person's provision of care and highlights important information or risks about the older person's situation that needs to be managed by the care provider or other parties.
- puts the older person at the centre of the Support Plan

Depending on the risk and issues highlighted in the assessment, the assessor must decide where to record the information in the older person's record, e.g., in the IAT, the Support Plan, in Notes, as attachments or as sensitive notes or sensitive attachments.

Assessment information and evidence should include all relevant documentation that supports the recommendations and decisions made throughout the assessment process. All documents must be submitted in PDF format. The assessment documentation must include:

- Consent
- IAT and Validated Assessment Tools (VATs)
- Additional Evidence
- Support Plan and Recommendations
- Notice of Decision letter
- Referral Information

The assessment should contain comprehensive information to support the justification of the assessor's recommendation for funded aged care approvals.

Recording sensitive information

If the older person shares (or the assessor is in receipt of) sensitive information, with the older person's consent this can be recorded by adding a sensitive note and/or a sensitive attachment on the older person's record. This information will not display to providers or to older persons viewing their information through the My Aged Care Online Account and will be visible only to assessors and contact centre/ACSO staff.

Sensitive notes should be used to record information that is of importance. This may include information about:

- financial issues
- safety concerns
- health issues
- legal situations
- past experiences of trauma

For example, a sensitive note could be used to record a personal safety issue such as conflict between family members causing the older person to be anxious.

Note:

Assessors must follow their reporting obligation specified in relevant legislation and protocols in their state or territory where they identify an older person is at risk of elder abuse.

Sensitive notes and attachments are not visible through the My Aged Care Service and Support portal. Instead, a message will display on the older person's record stating "the older person has a sensitive note/attachment on their record".

Given the assessor may be best placed to discuss the sensitive issues with the provider/s, the provider could contact the assessment organisation for enquiries on notes and/or attachments. The provider may also contact the assessor directly if they have a question concerning sensitive attachments. Sensitive information may be disclosed to the provider if it is relevant to their particular service. For example, where it is recorded that an older person has a sensitive health issue, an assessor may be contacted by a garden maintenance provider and the assessor may consider it inappropriate to disclose the information; whereas if the assessor is contacted by a personal care provider, the assessor may have a duty of care to disclose the information as it has implications for the service being delivered.

Where an existing older person currently receiving services has received a reassessment, and has disclosed new information that is categorised and recorded as a 'sensitive' note (that may impact the safety and welfare of the older person, staff or other older people), the assessor should contact the provider/s to make them aware of the sensitive information and enable them to make a risk-determination of how best to support the older person for the safe delivery of services (see section 12.11.4 older people who are in prison).

Sensitive user flag

The My Aged Care system also enables an older person or registered supporter to be flagged as a 'sensitive user' if the older person or registered supporter requests to limit access to their information, AND the older person or registered supporter:

- works for My Aged Care or the department
- has a conflict of interest with My Aged Care staff, or
- has provided reasonable justification to support that their identity and contact information is to be protected.