An older person or their registered supporter may request that the older person or the registered supporter is made a 'sensitive user' through the My Aged Care contact centre. The request will be assessed by contact centre team leaders and if appropriate the older person or registered supporter's record will be flagged as a 'sensitive user' record.

The details of a 'sensitive user' will remain available to assessors and service providers who are working with the older person. Older people or registered supporters who are flagged as a 'sensitive user' will need to disclose this status to the contact centre at the time of their interaction, as the information is restricted and will require a team leader to access and edit the record.

My Aged Care – Assessor Portal User Guide 4 – Navigating and updating the older person record

5.7.6. Urgent service provision in the IAT

The IAT includes a new question about an older person's need for urgent service provision, "Does the client require urgent service provision?" This a mandatory question and requires a Yes or No answer. The response to this question is one of multiple factors used by the system to calculate a priority category for the person for the Support at Home Priority System. Other information is also used to calculate a priority category. An older person's priority for ongoing funding is based on their personal circumstances and characteristics.

An older person can be determined to need urgent service provision if the older person:

- is considered at urgent and immediate risk in terms of their personal safety; and/or
- is at immediate risk of admission into residential care; and/or
- has a carer, and the carer arrangements are unsustainable, or the carer is at crisis point

The guide below has been developed to help assessors determine whether an older person requires urgent service provision.

Table 22. Urgent service provision guide

	Carer arrangements are unsustainable	Older person is at immediate Risk due to personal safety	Immediate risk of admission into residential care
	Indicators that a carer arrangement is unsustainable:	Some indicators of a person being at urgent and immediate risk with respect to their	There is an immediate risk of the older person entering Residential Care due to:

	Carer arrangements are unsustainable	Older person is at immediate Risk due to personal safety	Immediate risk of admission into residential care
Criteria for determining urgency	• Carer in crisis • Carer may have a dual caring role. • Carer's employment is being jeopardised by their caring duties • Carer may be returning to full time employment. • The level of care required by the older person is increasingly more complex and the primary carer is unable to provide the level of assistance required. • Recent changes in the older people' family, cultural, housing or social situation resulting in trauma, or feeling unsafe (including culturally unsafe) The carer in crisis is no longer able to provide care due to: • A change in the carer's personal circumstance i.e. death/significant decline in carers own health status • An inability to sustain their caring role due to a lack of	personal safety may include, but are not limited to: • Neglect of basic needs i.e., unable to access or prepare food resulting in malnutrition, weight loss or dehydration • Inadequate personal hygiene such as severe neglect of personal care leading to serious hygiene issues, infections or injuries. • Repeated hospital admissions due to frequent falls with sustained injuries. • Failure to administer necessary medications/treatments and/or attend medical appointments. For example, medication mishaps with potential for adverse outcomes. • Severe cognitive impairments with client engaging in risky behaviours (e.g. wandering) • Person is unable to safely navigate their home and community due to insufficient aids, equipment and/or home modifications. • Recent changes in the older person's family, cultural, housing or social situation resulting in trauma, or	• carer in crisis and/or inability of carer to offer required support; or • Lack of access to services to meet the older persons' needs and fairly mitigate immediacy of risk to personal safety • If the older person had access to these services (as soon as possible), they could be managed at home.

	Carer arrangements are unsustainable	Older person is at immediate Risk due to personal safety	Immediate risk of admission into residential care
	assistance being received i.e. the older person has significant needs and no (or minimal) support is being provided. **NOTE**: Carer in crisis is different to caregiver stress. Caregiver stress is a condition of exhaustion, anger, or guilt that results from unrelieved caring for a chronically ill dependent. The stress can vary depending on the individual and generally does not prohibit the carer from providing care. Caregiver stress can be reduced by accessing respite care.	feeling unsafe (including culturally unsafe)	

Adding concerns and goals

It is important to identify the goals the older person wants to achieve that are associated with the areas of concern that the older person wishes to address. The goals note the older person's strengths and abilities, the domain the goal(s) relate to, their area of difficulty and level of motivation to achieve the goal. The recommendations represent the agreed strategies and support to achieve goals. It is recommended that goals are added under 'Client concerns and goals' on the *Goals & recommendations* tab before accepting or overriding the IAT outcome.

After completing all relevant domains and categories in the IAT (noting that, once the IAT is finalised, answers in the IAT become read-only), the assessor and older person identify the goals the older person wants to achieve that are associated with the areas of concern that the older person wishes to address.

The goals should reflect the older person's current strengths, abilities, and areas of difficulty, along with the relevant domain and their level of motivation to achieve each goal. Recommendations must outline the agreed strategies and supports to help achieve these goals. Historical content from previous Support Plans should not be carried over unless it is clearly identified as historical or dated appropriately. Including outdated information can lead to confusion and reduce clarity. All content must focus on the older person's present needs and circumstances.

Assessors must:

- Draft Concerns and Goals that are clear, actionable, realistic and written from the older person's perspective (e.g., I find showering to be painful (concern). I would like to learn ways to have a shower without pain and reduce my pain rating from moderate (6/10) to mild to (3/10) (goal)).

- Link the older person's Concern to their needs as detailed in the relevant assessment domain in the IAT (e.g., Physical and Medical domains of the IAT provide details of Mr Arnold's functional limitations with showering and the pain he is experiencing).

    - Consider whether the older person will benefit from a short-term reablement intervention to maximise their independence, choice and quality of life, and the older person's capability, motivation, and strengths to contribute to their goals. Reablement can be provided by the assessor or by CHSP providers, with assessor review to determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.

    - Consider whether the goals identified suggest suitability for Restorative Care Pathway (RCP) such as improving function, learning, reablement, or other goals which support delaying the need for higher level or ongoing services. This consideration should include whether a person has the motivation and capacity to actively participate in RCP including attending frequent allied health interventions (over more passive interventions). The need for a multi-disciplinary allied health and/or nursing approach to care must also be required before recommending RCP. Consideration of long-term needs should also be given before approving RCP as it will impact their position on the Support at Home prioritisation system.

    - Consider whether available units of funding for the RCP are low. If the recommendation for the RCP classification may not approved by the Assessment Delegate due to no units being available, assessors could contact the older person to discuss alternative supports for recommendation.

    - Consider, throughout the assessment, whether the older person will benefit from assistive technology and home modifications funding to support functional needs and safety at home in areas such as:

        - managing body functions
        - self-care
        - mobility
        - domestic life
        - communication and information management

5.7.7. IAT outcome

If an assessor plans to recommend ongoing home support for an older person through Support at Home (SaH) or Commonwealth Home Support Program (CHSP), the IAT Outcome that is generated by the system must first be accepted by the assessor. For example, where the IAT Outcome recommends an ongoing SaH 5 the assessor will accept this IAT Outcome.

If the IAT Outcome results in 'ineligible for CHSP/SaH', the person is not eligible to receive CHSP or ongoing SaH. In this circumstance the system will display a prompt to override to a higher classification. Assessors must not take this action. If by considering the eligibility criteria in the *Aged Care Act 2024* for residential care or transition care, the assessor wants to recommend these care types, it is appropriate to accept the ineligibility outcome and recommend these care types.

The IAT Outcome is designed to consistently determine an older person's CHSP or SaH classification, or their ineligibility for ongoing home support services. It is guided by a set of rules that are built into the IAT to generate a classification level (funding) for ongoing home support. The criteria that an older person must meet for each classification level are defined in section 81-10 of the *Aged Care Rules 2025 (the Rules)*.

The IAT Outcome considers a client's needs at three levels:

- Identification of the older person's functional abilities.
- Assessment of how well the older person's functional needs are currently being met.
- Consideration of compounding factors, which introduce additional complexity for a client compared to others with similar functional status and level of met needs.

This approach ensures that people with similar characteristics and functional needs receive the same level of funding to support their aged care needs.

The new system is designed to:

- **Achieve consistency** – so that decisions are not influenced by individual discretion or subjective judgment.
- **Ensure equity** – so that everyone is treated fairly.
- **Build confidence** – so older people and their families can trust that the system is transparent and reliable.

Note: Given this new approach, a guidance framework akin to the *Guidance Framework for Home Care Package Level* does not exist for assessors to recommend Support at Home classification levels.

Important: To support the IAT Outcome recommending a level of care which appropriately addresses an individual's care needs, assessors should ensure all inputs into the IAT are accurate before it is finalised.

Overriding the IAT outcome

It will be necessary to override the system-generated IAT Outcome to recommend the:

- SaH Restorative Care Pathway,
- SaH End of Life Pathway,
- Transition Care Program (TCP),
- Permanent Residential Care without ongoing in-home services,
- Residential Respite care without ongoing in-home services.

Note: in order to recommend TCP or only residential care (permanent or short-term), assessors will need to override the IAT Outcome of CHSP or Support at Home to 'ineligible for ongoing SaH/CHSP'. Assessors can then recommend these care types in the support plan.

In very limited circumstances where TCP is recommended alongside SaH services, an assessor should accept the SaH classification generated by the IAT Outcome and add TCP as a care type in the Support Plan.

If the IAT Outcome has recommended 'ineligible for CHSP/SAH' and the assessor, in considering the eligibility criteria in the *Aged Care Act 2024,* considers it appropriate to recommend transition care or residential care, they can accept the ineligibility outcome and recommend these care types.

Once the override button is selected, a screen will display where an assessor can perform these actions. If an assessor overrides the IAT outcome, they will be required to:

- select a reason for overriding the IAT outcome, and
- provide a descriptive reason for overriding.

Important:

The IAT Outcome has functionality that allows for particular actions that must not be taken by assessors as these actions do not align with the *Aged Care Rules 2025 (the Rules)*. This functionality includes:

- a CHSP classification can be overridden to recommend Restorative Care Pathway (RCP) during a comprehensive assessment. In line with section 81-15 of the Rules, RCP cannot be recommended for approval when a Support at Home classification has not been generated by the IAT Outcome.

-the IAT Outcome can be overridden to recommend a different ongoing home support classification (e.g. SaH class 5 to SaH class 6). In line with section 81-10 of the Rules the criteria for each classification is prescriptive and does not allow for an ongoing classification different to the IAT Outcome to be recommended.

It is important that assessors do not take these actions and delegates do not approve recommendations when these actions have occurred.

Tips for assessors when explaining the IAT outcome and recommended classification level for ongoing home support to older people and their supporters.

- I have put the information you/<older person's name> have/has given me during your/their assessment into the assessment tool and the system has generated an outcome for your/their <eligibility for CHSP/level of funding for Support of Home> OR <ineligibility for ongoing home support services>.
- The system uses a set of rules which rely on information that you/they have told me during your/their assessment which include:
    - Your/their functional ability to undertake daily tasks e.g. walking, eating, bathing, toileting, managing their finances, cooking, and shopping, and
    - the extent to which your/their needs are currently being met, and

    - other factors that may introduce additional complexity for you/them such as sensory concerns, medical conditions and co-morbidities, carer availability, mental health, continence, and vision impairment.
- Using this set of rules, the assessment tool has determined your/their level of funding for ongoing home care services.
- This helps to ensure consistency in how funding packages are assigned and means that your/their funding level will be the same as other people who have similar needs and clinical characteristics.
- I have included services in your support plan that will help to meet your goals and needs. Once approved and your funding is assigned to you, you can work with a provider to determine the services you will receive and how often within your classification level (funding).

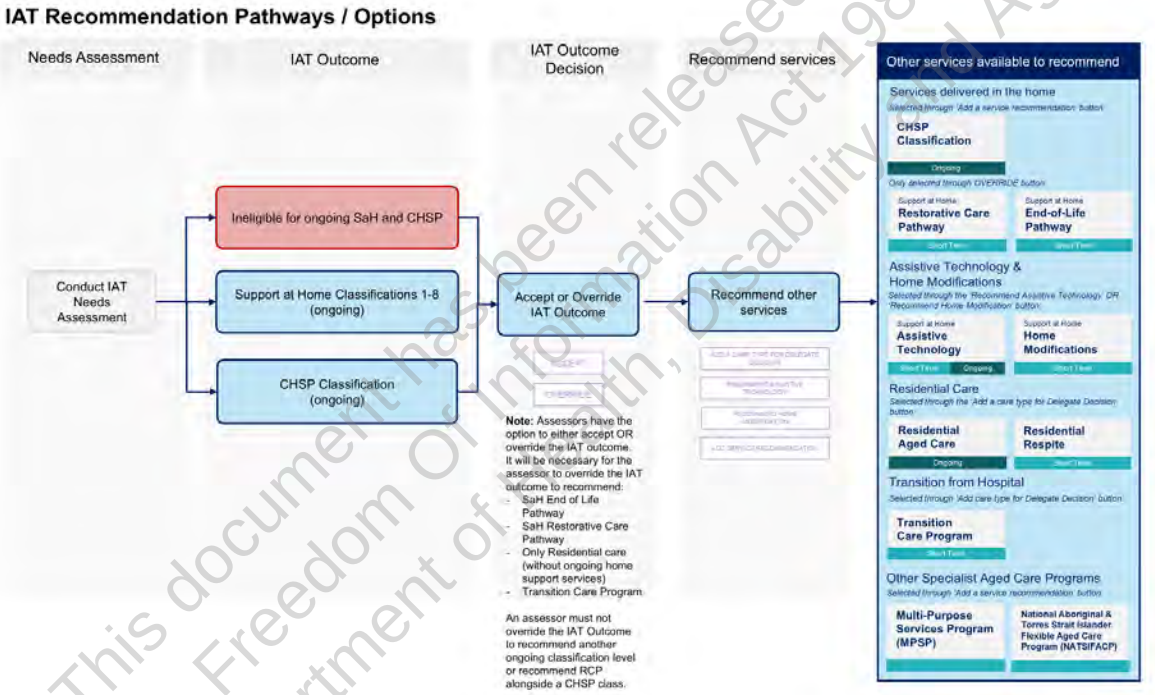

Figure 4 - IAT recommendation pathways and outcomes

5.8. Converting a home support assessment to a comprehensive assessment

If an assessment is triaged as a home support assessment and the IAT outcome generates a Support at Home classification or the assessor wants to recommend residential care (permanent or short term) , the assessment will need to be converted to a comprehensive assessment under the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal.

Note: Enrolled Nurses (EN) who hold the clinical assessor role cannot provide clinical supervision to non-clinical assessors. This is considered outside an EN's scope of practice.

In the expanded view of the *Goals and Recommendations* tab, the assessor will have the option to convert to a comprehensive assessment if the current assessment type is Home Support. An assessor will only be allowed to convert to comprehensive assessment from a home support assessment.

In assessments where services under the Support at Home program and/or residential care are recommended, but clinical questions are not triggered in the IAT during the assessment, an assessor will need to seek the supervision of a staff member who holds a clinical assessor role in the My Aged Care Assessor Portal. The supervising assessor will need to be nominated before the assessment will be converted.

If a clinical assessor has already provided clinical attendance during the assessment and nominated as the supervising assessor, the details saved when the IAT was finalised will display as read-only.

When the assessment is finalised, a system notification 'Notification of Supervised Assessment' will be sent out to the outlet associated with the nominated supervising assessor. This notification will be visible on the Assessor Portal as per existing notifications functionality.

5.9. Developing a high-quality support plan

The Support Plan is a plain language summary of the older person's situation, strengths, goals, aged care needs and recommendations, based on information obtained during the completion of the IAT.

The Support Plan sections include:

- Assessment summary
- Concerns and goals
- Service recommendations

The role of an assessor, when developing the Support Plan with an older person, is to consider IAT findings and the older person's needs holistically to recommend support most appropriate to their needs and circumstances.

Note:

As of 1 November 2025, the Support Plan functionality in the system is changing to accommodate the Support at Home classes and associated service recommendations and AT-HM scheme. The Support Plan printed document that's sent to the client is not changing substantially, other than a few wording tweaks for usability and to align with the Act.

Once finalised, the Support Plan is sent to the older person, and their registered supporter/s and/or appointed decision maker/s as applicable (via post and/or email), as a record of the assessment, accompanied by a Notice of Decision letter. Registered providers also use the support plan to inform the individual's care plan; therefore, accuracy and clarity is essential.

Referral codes will be included in the Support Plan for the majority of services approved however there are several nuances about where they will appear depending on the program or pathway. For further detail on how referral codes will be communicated to clients and providers, see Chapter 7 'Post Assessment Referral and Services Access'

5.9.1. Assessment summary

The assessment summary section of the Support Plan is a succinct overview of the assessment that appears on the Support Plan for the older person.

When completing the assessment summary, the My Aged Care system allows the assessor to pre-populate a summary of the older person's functional ability, support considerations and complexity indicators that were identified during the assessment. The pre-populated information will be displayed in the ISBAR format, which is the required template for recording information in the assessment summary.

Assessors must use a standard template (see ISBAR approach below) to complete the assessment summary to ensure information is recorded in a consistent manner across assessment types. It is simple to adopt and helps make information easier to read while better supporting the delegation process and assisting the service provider to develop the care plan.

The assessment summary must:

- Be written in a succinct manner (using the ISBAR approach), focusing on relevant/essential information.
- Be presented in a structured way that makes the information easy to interpret.
- Be grammatically correct and free from acronyms, abbreviations, jargon, and unnecessary headings.
- Provide a holistic and complete summary of the older person's assessment at that time.
- Be relevant. Only include information that is relevant to the older person's current situation. This may mean updating previous information.

Assessors must also:

- Use the 'pre-populate' function in the Assessor Portal to enable the ISBAR template to tailor the pre-populated assessment information in consultation with the older person. Ensure the Assessment summary is not limited to pre-populated information but includes a holistic, comprehensive view of the older person as per

information collected from the assessment. Information must not be in dot point form and should be re-written in a sentence format this is readable to the older person. See template in the Table 21 below.

- Review and edit information populated from the assessment – such as functional needs, health conditions, support considerations, and complexity indicators. For a SPR or reassessment, the assessor (in updating previous information) may need to remove content that is no longer current to remain within the 5000 character system limit. All past versions of the Support Plan are retained as a record of any deleted content. Each Support Plan must reflect the older person's current needs and circumstances. Historical content needs to be clearly identified or removed to ensure clarity of current needs.
- If clinical attendance occurred during the assessment process, the assessor must make a note of this in the Support Plan.
- Note: Enrolled Nurses (EN) who complete a comprehensive assessment must include a statement in the support plan that the assessment has been conducted under direct or indirect RN supervision within the same organisation

All support plans within the assessment summary must be written using the ISBAR approach. It is expected assessors use the ISBAR format as a guide on how information is structured in the assessment summary with clear headings and subheadings where required. This ensures readability for not only the older person, but for their carers, service providers or future assessors, providing a holistic view of the assessment and older person.

Note to Aboriginal and Torres Strait Islander Assessment organisations:

Assessors should be mindful that the Support Plan should be written in a way that can be understood by the older person and their support network. If needed, the assessor may follow up with the older person to explain the Support Plan to the older Aboriginal and/or Torres Strait Islander person.

Table 23. Assessment summary template using the ISBAR approach

ISBAR topic	Assessment information
Introduction	• Older person's name and age • Reason for assessment, including referral details (who made the referral and why, if appropriate) • Assessment details – type (home support or comprehensive), date, location, mode, attendees, assessor name
Situation	• Key health conditions that impact functional limitations and need for an aged care assessment • Medical issues (clinical assessors to include diagnosis status) *

ISBAR topic	Assessment information

Background	• Living arrangements*
	• Current social situation and social history*
	• Current support
	  o Carer support (including details of Power of Attorney in place)
	  o Other informal supports*
	  o Current services including aged care, mental health, disability, palliative care

Assessment	• Carer profile • Function • Medical and medications • Physical and personal health and frailty • Social • Cognition • Behaviour • Psychological • Home and personal safety • Financial or legal • Support considerations • Whether clinical attendance was sought by a non-clinical assessor • Reference the use of any validated assessment tool (including those conducted through use of clinical attendance), the outcome of the tool and how that outcome was incorporated into the assessment.

Recommendations	• Previous approvals
	• Current recommendations*
	  o Reason for the recommendation (the older person benefit from X)
	  o Comments relating to the urgency of service
	  o Who is to action the recommendation – older person, assessor
	  o Recommendations associated with the carer or associated people support
	  o Recommendations are linked to assessment outcomes and/or the older persons Goals and Concerns.
	• Referrals*
	  o Status of referral (e.g., referral made with consent, older person declined referral)
	  o Who is responsible for contacting services
	  o Time-limited/end date or review date, or a rationale for ongoing services.
	• Contact details (if not older person) *

ISBAR topic	Assessment information
	Who has been sent a copy of the Support Plan, including whether it has been linked to the older person's My Health Record*

*Indicates items that are not pre-populated

Further guidance on **the information that should be included under each heading is below:**

Situation section: Ensure this section outlines the primary reasoning for the referral for aged care reason including any linkages to functional, social, psychosocial and environmental factors. This section should include an older persons' medical history with specific reference to the primary health condition(s) that impact their activities of daily living and/or social situation. Include any recent hospitalisations or access to ongoing medical intervention. This should link to any medical services the older person is currently receiving including any specific specialists, doctors or other medical professionals they are currently seeing (e.g. GP)

Background section: Include information that pertains to the older person's current social situation and any social history with details on living arrangements, work and/or social engagements. This includes caring arrangements (formal or informal) that are in place for the older person and what specific supports they are currently providing to the older person. This should also outline any carer stress or carer sustainability issues pertaining to the older person. Assessors should outline any aged care services or other government or state-based services that are being accessed at the time of the assessment.

Assessment section: include all relevant sections of the assessment and highlight any complexity indicators. It should include all validated assessment tools and its scores that were used in the 'assessment' section along with an explanation of what the score indicates. The assessor should exercise clinical judgement on whether specific scores should be excluded (e.g. sensitivity content for the older person)

Recommendation section: provide information on how to link the older persons' goals to the service recommendations and approvals.

Note:

Where a comprehensive assessment was conducted by an Enrolled Nurse under the supervision of a registered nurse according to the Nursing and Midwifery Board of Australia - Enrolled nurse standards for practice, this must be stated in the introduction of the Support Plan. Additionally, the name of the registered nurse must be recorded within the Support Plan.

5.10. Wellness and reablement approach

Wellness and reablement are person-centred, holistic approaches to service delivery. They build on people's strengths, capacity and goals to promote greater independence and autonomy. Wellness and reablement approaches are based on the premise that,

even for individuals who experience frailty, older people want to improve their physical, social and emotional wellbeing, and remain living at home, connected to their community.

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

5.10.1. Delivering reablement

The provision of wellness and reablement approaches should be embedded in the assessment and support planning processes. Wellness and reablement underpins all assessment and service provision, drawing on the wellness philosophy to inform a way of working with people. Wellness and reablement are inclusive approaches that involve assessment, planning and delivery of supports that build on the strengths, capacity, and goals of individuals irrespective of age, capacity, diagnosis or setting[3]. Additionally, these approaches build on people's strengths and goals to promote greater independence and autonomy in daily living tasks, as well as reducing risks affecting the ability to live safely at home. They avoid 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves (or with less assistance), and to increase satisfaction with any gains made.

Reablement approaches involve time-limited services for a period of up to 12 weeks and always include a specific goal. Time-limited support aims to address a specific barrier to independence and to support the older person getting back to doing things for themselves. This involves a targeted timeframe, developed with the older person, to achieve their goals.

It should be noted that wellness and reablement approaches should be adopted by all assessors, including clinical assessors. For clinical assessors who are undertaking a comprehensive assessment, the option is also available to recommend an older person to receive a reablement service under CHSP if it is appropriate to do so.

A wellness and reablement approach to assessment means where possible, assessors undertake a 'show me' (active) assessment in which older people demonstrate how they undertake certain tasks to better understand their limitations and identify risks. This is distinct from the traditional "tell me" approach used by assessors.

Understanding what a good day looks like for an older person and how it relates to their individual goals and outcomes is important to determine short-term support needs during an assessment. This could be maintaining a level of activity or independence or working towards regaining it. Time-limited reablement is usually delivered within a 12-week period with the aim to wrap up and cease the services when the older person has met their goal or specific outcome.

Time-limited reablement under the CHSP that assessors may refer older persons for can include:

[3] Metzelthin, S.F., Rostgaard, T., Parsons, M., & Burton, E. (2020). Development of an internationally accepted definition of reablement: a Delphi study. *Ageing and Society, 42*, 703 - 718.

- Learning a new skill, or actively working to regain or maintain an existing skill modification to a person's home environment,
- Providing access to assistive technology to help live more independently and safely in the home.

For example, learning a new skill could require referral for support on how to prepare simple meals for themselves, rather than referring for meals delivery. Regaining or maintaining existing skills could require referral for Allied Health and Therapy Services to ensure the older person can continue to transfer around the home and reduce the risk of falls.

As part of the assessment process, the assessor will need to work with the older person to identify whether they would benefit from a reablement approach to home support services, based on their needs and goals.

If the older person agrees short-term reablement support is appropriate and/or beneficial to them, the assessor should include service solutions within the Support Plan to promote their independence. The assessor must record the reason for the reablement period within the Support Plan such as:

- rebuild confidence and independence in mobility
- rebuild confidence and independence in cognitive abilities
- adaptation to functional limitation
- support the development/relearning of daily activities
- task simplification and energy conservation for managing housework
- promote social contact, community access and participation
- skills development in using public transport
- supporting independence through assessment for appropriate assistive technology
- training in the use of assistive technology
- supporting independence through assessment for home modifications ensuring safe living environments.

The Support Plan may include recommendations to assist the older person to maintain and strengthen their capacity to continue to undertake daily activities and maintain social and community connections. Due to the nature of reablement supports, it is possible there will be several items in the Support Plan that need to be delivered in a coordinated way across a number of service types over a limited time period. In these circumstances, the assessor could refer an older person to a lead provider – the organisation or individual provider who will deliver the key services as identified in the Support Plan.

The assessor may also need to take on a coordination role to ensure that all services in the Support Plan are linked to a CHSP provider, and that they will all be delivered within the timeframe of the overall reablement service. For older people receiving reablement support, assessors must include review dates on the older person's Support Plan for the purposes of reviewing the older person's progress towards their goals and desired outcomes, requirement for ongoing services, or whether to adjust the services required.

The reablement function on My Aged Care is designed so that the Support Plan can be finalised but also kept open for the support period to allow additional edits to be made (by the assessor who completed the assessment). The timeliness Key Performance Indicator (KPI) will not be impacted. The timeliness KPI ends at the "finalise Support Plan & keep open for support period".

For a smaller sub-set of older people, CHSP restorative care may also be appropriate, where assessment indicates that the older person has potential to make a functional gain. Restorative care under CHSP involves evidence-based interventions led by an allied health worker or professional that allows a person to make a functional gain or improvement after a setback, or to avoid a preventable injury.

The department's expected proportion is that assessment organisations recommend a period of reablement, which will include reablement based strategies and short-term support from the Aged Care Assessor and, where required, a referral to short term CHSP Reablement based support services, to a minimum of 10% of older people.

The following Steps/Activities are required for facilitating reablement:

- Consider if the older person would benefit from short-term reablement support, particularly if the older person has experienced some functional loss and expresses the desire to improve independence and/or regain confidence and capacity to resume activities, including connecting with their community.
- Where reablement is to be provided by one or more CHSP providers, recommend a period of reablement on the older person's Support Plan. This function allows assessors to identify older people who would benefit from reablement and allow assessors to make changes to the older person's Support Plan during the reablement period. Users accessing the older person's record (such as older people and service providers) will be informed that the older person is undergoing a period of linking support and/or reablement.
- Focus on elements of functional tasks that an older person can complete, and discuss what specific assistance they would benefit from in order to complete the task by themselves (to maintain and continue the independence to live at home)
- Discuss strategies an older person can employ to more easily manage day-to-day tasks (e.g., transport planning to meet goals around the use of public transport to maintain usual activities)
- It is important to ask what goals the older person wants to achieve. This can be as simple as making a cup of tea without help, or to understand their bus timetable. A goal could be walking to the local bus stop to go shopping, or to get to regular senior's events. Even small goals go a long way towards building self-confidence and regaining (or maintaining) skills to get back to doing things for oneself, to be more independent;
- When looking at what goals the older person could achieve, start by asking what a good day looks like for them? Then work out with the older person what goals they need to achieve to have more of those good days.
- Consider the older person's need for a mix of short-term, episodic, or ongoing services across CHSP service types (e.g., short-term personal care, episodic allied health, ongoing transport). Review this approach regularly to ensure the intensity of services matches the older person's needs.
- Maintain regular contact with the older person and providers and during the period of reablement.
- In consultation, determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.
- Develop local knowledge of reablement-type services in the region. Discuss with local providers their capacity and willingness to take on short-term older people as part of a reablement episode.
- An expanded in-depth description of Supporting Independence: Reablement including older person scenarios is at Appendix F.

Department of Health, Disability and Ageing website:

- Commonwealth Home Support Program (CHSP) 2025-27 Manual | Australian Government Department of Health, Disability and Ageing
- Wellness and reablement resources
- Living Well at Home – CHSP Good Practice Guide

5.10.2. Linking supports

The department has established services that will assist clients requiring support to access aged care services, including Care Finders, and Elder Care Support services.

For Aboriginal and Torres Strait Islander assessment organisations, Elder Care Support workers can be key partners in delivering culturally safe, trauma-aware, and healing informed assessments. where it is needed.

With a client's consent, Elder Care Support workers could attend an assessment to provide trusted experience for the older person. The assessor should work closely with Elder Care Support staff to facilitate a warm handover. This collaboration ensures continuity of care and supports a culturally safe and trusted transition for the older person into aged care services.

If an Elder Care Support worker has not been engaged prior to the assessment, the assessor should assist the older person in connecting with Elder Care Support services delivered by Aboriginal Community Controlled Health Organisations This support can help build trust, improve understanding of the aged care system and facilitate a smoother transition into services.

Department of Health, Disability and Ageing website:

- List of Elder Care Support Providers | Australian Government Department of Health, Disability and Ageing

Where a client's complex circumstances may be impeding their access to aged care services, Linking Service Support will assist in linking them to the various services they require to live in the community with dignity, safety and independence. The aged care needs assessor must determine if a client requires Linking Service Support.

Linking Service Support activities are aimed at working with the client to address areas of vulnerability that are preventing access to receiving mainstream aged care support, to the extent that the client is willing or able to access aged care services. The issues include homelessness, mental health issues, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage and cognitive decline.

Linking Service Support through the Assessment Organisation is limited to short-term case management or care coordination to the Point of Effective Referral. It is not designed to provide ongoing support services. The role of the aged care needs assessor is finalised when:

- a referral for Services is accepted by a Service Provider.
- the client has accepted responsibility for managing their own referral for services;
- the client has made a choice not to proceed with aged care needs assessments or aged care needs assessment related services; or
- the outcome of the aged care needs assessment is that no further action is required by the aged care needs assessor.

If longer term support is needed, with consent from the older person, Elder Care Support workers or care finders should be engaged to help clients navigate the aged care system.

Key Performance Indicators have been set by the department for assessment organisations to increase the referral of older people to time limited Linking Services Support. This KPI specifies that 2.5 per cent of all clients will receive a time-limited Linking Services Support to address areas of vulnerability that are preventing access to receiving mainstream aged care support. Support may include short-term case management and non-aged care support.

Delivering linking support/care coordination to vulnerable older people

Facilitating linking support can greatly benefit some older people whose circumstances may impede their access to aged care services. Linking support may be conducted by providing short-term case management or care coordination to the point of effective referral. Activities are aimed at working with the older person to address areas of vulnerability which prevent access to receiving mainstream aged care supports or care, to the extent that the older person is willing or able to access aged care services. Issues leading to vulnerability could include homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage, cognitive decline and/or living in a remote locality.

Assessment organisations are expected to provide short-term case management services for vulnerable older people who require linking services.

Identifying a vulnerable person for linking support

The IAT is designed to assist an assessor to identify the complexity of an older person who may require linking support. Assessor judgment also plays a significant role, noting the presence of the same risk in different people may signify varying degrees of vulnerability. If applicable, the assessor selects from the following complexity indicators.

The older person:

- is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing, and ability to remain living in the community,
- is at risk of, experiencing (or suspected to be experiencing) abuse,
- has emotional or mental health issues which significantly limits self-care capability, requires intensive supervision and/or frequent changes to support,
- is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support,
- has experienced adverse effects of institutionalisation and/or systems abuse (e.g., spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing,
- is exposed to risks due to drug and/or alcohol related issues and is likely to cause harm to themselves or others,

- is exposed to risks or is self-neglecting of personal care and/or safety and is likely to cause harm to themselves or others,
- has a cognitive impairment (e.g. memory problem or confusion) that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support.

The assessor may also need to consider challenges faced for people living in remote or very remote regions.

The assessor then selects, if applicable, the 'Risk of Vulnerability Cohort' from the following:

a) Culturally and linguistically or ethnically diverse individual; and/or
b) Aboriginal or Torres Strait Islander
c) Living in a rural or remote area
d) Financially or socially disadvantaged
e) A Veteran
f) Homeless or at risk of homelessness
g) Lesbian, Gay, Bisexual, Transgender, Intersex, or other gender diverse
h) Individuals
i) A person separated from their parents or children through forced adoption or removal
j) A socially isolated individual
k) Other (assessor to specify)

Further information on identifying and supporting vulnerable cohorts is included in Chapter 12 'Supporting Diverse Experiences and Needs'.

Following this, the assessor will decide whether the person would benefit from Linking Support by considering and selecting (if applicable):

(a) whether complexity indicators impact the older person's ability to live independently in the community

(b) whether urgent intervention is required and

(c) whether the older person has indicators that impede access to delivery of aged care services.

Where the access to delivery of aged care services might be impeded, the assessor is to recommend Linking Support and short-term case management.

Linking support and short-term case management activities

The level of linking service support offered by assessors is time-limited and is not designed to provide ongoing support services.

However, it is understood that in some circumstances due to ECS services not being available in their area or due to preferences of older people who have already established trusted relationships with an assessor from an Aboriginal and Torres Strait Islander assessment organisation, an assessor may have a role in providing ongoing case management services to their clients.

The activities that an assessor chooses to undertake when providing linking support will be dependent on the needs, circumstances, and preferences of the older person, and may include one or more of the following:

- **Information provision and tailored advice** – provision of clear, reliable, up-to-date, and relevant information and advice to older people regarding service options and pathways.

- **Guided referral** – facilitation and management of the process of linking a vulnerable older person to appropriate service pathways within or outside the aged care system. This includes monitoring the success of the referral process and ensuring that linking to the appropriate services is achieved.

- **Service coordination** – where an older person's needs are complex and require a range of services spanning multiple sectors, the assessment organisation oversees the coordination of these services.

- **Advocacy activities** – for the vulnerable older person to gain access to the identified support services, the assessment organisation may be required to speak, act, and write to the identified service providers on behalf of the vulnerable older person.

- **Case conferencing/multidisciplinary service coordination** – provision of comprehensive, integrated service coordination for older people with high-level needs. This involves using a case conferencing/multidisciplinary service coordination approach which brings together a number of team members and a suite of services across sectors in order to meet the older person's needs at different levels.

- **Establish local knowledge and networks** – the assessment organisation establishes local connections with service providers which support vulnerable people in their region.

- **Administrative tasks** – establish and undertake the administrative functions necessary to support the smooth and seamless progression of vulnerable older people through the required services. Some examples are:
    - Contact the relevant service providers on behalf of the older person (e.g., legal services, health services, housing services etc.)
    - Obtaining the necessary older person information from various sources and organisations
    - Compiling and completing the necessary forms on the older person's behalf
    - Organising relocation services for the older person, if required (e.g., removalist and utility services)
    - Organising cleaning services for the older person's place of residence, if required
    - Documenting the older person's progress.

It is expected that assessors will work closely with vulnerable older people on a low income who are living with hoarding behaviour or in a squalid environment and at risk of homelessness or unable to receive the aged care services they need. Where there is no coverage for hoarding and squalor assistance, the eligible older person can be referred to CHSP services such as social work and other services targeted at avoiding or reducing

the impact of hoarding and squalor situations (see Chapter 6 Aged Care Programs – Hoarding and squalor assistance).

All Care Finder and Elder Care Support Program clients seeking aged care services must be assessed by My Aged Care via the assessment services to determine eligibility and the need to receive additional CHSP services. People receiving assistance through the Care Finder program or Elder Care Support program may be eligible to access CHSP services targeted at avoiding homelessness or reducing the impact of homelessness. Any entry level CHSP services made available to a Care Finder or Elder Care Support Program older person between the age of 50 and 65 must be targeted at avoiding homelessness or reducing the impact of homelessness.

Refer to Chapter 12 for more information on support for a vulnerable person.

My Aged Care system function – linking support

The linking support function on My Aged Care provides assessors with the opportunity to record activities for older people identified as benefiting from linking support. The function allows assessors to make changes to the older person's Support Plan during the linking support period. Users accessing the older person's record, such as older people, contact centre and service providers, will be informed that the older person is undergoing a period of linking support. The department's expected proportion is that assessment organisations deliver linking support to a minimum of 2.5% of older people.

The function is designed so that the Support Plan can be finalised and kept open for the support period and the timeliness KPI will not be impacted. The timeliness KPI ends at the 'Finalise Support Plan & keep open for support period'.

5.11. Vulnerable older people relating to aged care services

Where the assessor wishes to monitor the older person's access to aged care services more closely, they can elect (or at the older person or appointed decision maker's request) to be notified of correspondence sent to the older person. This particularly applies to vulnerable older people who need assistance with the process of finding a suitable provider, and do not have support to assist them. Only one person from an assessment outlet can be selected to receive this notification. This person's contact details will also appear on all correspondence with the older person.

An assessor should also consider whether a person can access support through the Care Finder and Elder Care Support Program.

This notification can be enabled from any tab in the older person's Support Plan or on the 'Approvals' tab in the older person record. The notification link will only be enabled if the older person has been marked as 'seeking services', or a recommendation has been made.

Where an assessor is receiving Support at Home notifications for a vulnerable older person who has been approved to access funded aged care services, the assessor is able to extend an older person's acceptance period for ongoing services beyond the 56-day entry period, and extend the older person's time to select provider for an additional 28 days through the extension process on My Aged Care.

Care finder program | Australian Government Department of Health, Disability and Ageing

Elder Care Support | Australian Government Department of Health, Disability and Ageing

The assessor must carry out the following steps and activities:

- Consider if linking support is required – particularly if the older person presents with two or more complexities (and/or risk of vulnerability) – and may have been further confirmed through the support considerations process.
- If identified as 'vulnerable', with the older person's agreement, the older person will be provided with linking support. If not applicable, check an appropriate plan is in place. Therefore, the IAT and/or the Support Plan evidences the complexity or risk of vulnerability support has been considered and documented. If linking support is applicable, develop the Support Plan to include linking support, recommending the period of linking support and the planned activities. Action the recommended activities, monitor progress and record the outcomes (using the linking support function).
- Consider all available care and support options appropriate to the needs of the older person and facilitate the provision of services to the point of effective referral.
- Liaise, consult, and work collaboratively with all stakeholders and service providers in a multidisciplinary approach across service sectors to support individual older person needs. For example:
    - Contact relevant experts and service providers to discuss the older person's current situation and Support Plan moving forward, and to assist with the co-ordination of the older person's care whilst receiving linking support (e.g., care finders, CHSP Hoarding and Squalor providers, health, housing and legal services, community Geriatric Evaluation and Management teams, advocates, social, case management and/or mental health workers and local councils).
    - With older person's consent, obtain the necessary older person information from various sources and organisations.
    - Maintain regular contact with the older person, providers, and those co-ordinating services during the period of linking support.
    - Assist older people with issues relating to transition to alternate service options.
    - In consultation with the older person, determine when the linking support period should be finalised, and what ongoing support (if any) may be required for the older person
    - If aged care service access is not approved, consider referral to a support service outside of aged care and if relevant a support service which provides a coordination or case management function.
- Offer the information in a variety of formats to promote equitable access (e.g., paper-based, electronic, face-to-face, over the phone, etc.) and where appropriate, include information to self-refer to the identified services and supports and information on rights, responsibilities, and mechanisms for complaints.

5.12. Recommending aged care services

Note:

Service approvals are a fundamental change under the Aged Care Act 2024. Providers will be unable to deliver or claim for any services for an individual that is not approved in the support plan (even if there is an immediate need).

Once the IAT has been finalised, an assessor will assess an older person's need for aged care services as defined in **Sections 66 to 68** of the *Aged Care Act 2024*.

As an assessor, if you recommend that an older person's access to ongoing Support at Home, Restorative Care Pathway or End-of-life Pathway, assessors will be taken directly to the 'Add Home Support services' page. On this page specific services are grouped by service type. These service types relate to the services in the Aged Care Rules 2025.

Under each service type, specific services will appear (known as service levels). For example, under the service type *Domestic Assistance*, services such as general house cleaning, laundry service, shopping assistance etc. will display. All services are pre-selected, except for services in the 'prescribed' service types *Allied health and Therapy* and *Therapeutic Services for Independent Living*. This is due to the specific nature of these services and should only be recommended if an older person has a need for them.

Important:

For any service type other than *Allied health and Therapy* and *Therapeutic Services for Independent Living* (the 'non-prescribed' service types), if you think the older person needs <u>any</u> service in the service type, then you need to select <u>all</u> services in the service type.

This is because, for the non-prescribed service types under the Act, an older person is approved for access *at the level of service type only*. This applies to service recommendations for Support at Home classifications and CHSP.

Under Section 65 of the *Aged Care Act 2024* an older Aboriginal and Torres Strait Islander person only needs an approval at the level of service group and classification type to receive aged care services. This means that if the older person is approved for a service group, they are automatically approved for *all service types and services* in that group.

In the system, however, for the *home support* service group you must ensure all service types and services are selected in the 'Add home support services' page, if the older person is Aboriginal or Torres Strait Islander. If you add Assistive Technology, Home Modifications or residential aged care to the support plan, there is no need for you to select specific services.

On the *Add Home Support services* page, assessors can also:

- recommend the frequency and intensity of services
- link the older person's concerns and goals to the services that have been selected.

Care types and services that are not part of Support at Home can be recommended by clicking 'Add a Service Recommendation' or 'Add a care type for delegate decision' under *other recommendations* in the *Goals & recommendations* tab. This applies to MPSP and NATSIFACP services, Residential Care, Transition Care and CHSP.

5.12.1. Making service recommendations

There are two types of recommendations that can be made on the Support Plan:

a) **Service recommendations** represent referrals that can be made through the Assessor Portal to Commonwealth-subsidised aged care services.
b) **General recommendations** relate to a type of support that is non-government funded or where a referral is made outside of the Assessor Portal. All recommendations – whether government-funded services, specialist programs, linking support, or general actions – must be clearly documented in the Support Plan.

Recommendations for aged care services must be aligned to an older person's current needs. If multiple services are recommended, the assessor must clearly link each service to a relevant concern and goal. If there are no recommendations as a result of the assessment, the assessor must provide clear reasons for the outcome within the Support Plan and communicate clearly to the older person.

Assessors must clearly articulate the service recommendation details – service type and services (if applicable), start, end and review dates (if applicable), frequency, intensity, priority, and outcome:

- The frequency and intensity of the services may be recorded if indicated, however may be decided at a later point by the service provider with the development of the Care Plan. Example: Two times weekly.
- The priority for the service recommendations is based on the older person's needs and urgency for services. The determination of urgency for services is based on the older person's circumstances, such that there is an urgent need for services which, if not met immediately, may place the older person's health and safety at risk.
- Include CHSP service (short-term or ongoing) information in the assessment summary (see previous sub-section: Assessment Summary).

Note:

If a non-clinical assessor is recommending services other than CHSP, they must seek the supervision of a clinical assessor to assist with providing recommendations for those services e.g. Support at Home ongoing, residential care and AT-HM.

If clinical attendance occurred during the assessment, this supervision should be given by the clinical assessor who provided this attendance.

If services that are not CHSP services are recommended and clinical questions were not triggered in the IAT, the non-clinical assessor will need to seek the supervision of a clinical assessor upon converting the assessment to a comprehensive assessment.

Detail all care options agreed with the older person, ensuring general and service recommendations:

- Are evidence-based, defensible and are clearly drawn from and linked to the older person's goals and needs/area of concern. For example: a recommendation for respite, links to information on the older person/carer relationship, dementia support, and any difficulties or concerns that are experienced to reduce carer stress and support the care relationship.
- relate to the older person's current unmet needs and are supported by the assessment.
- take into account their identified support considerations when recommending options for support.
- consider the availability and capability of services and supports to meet the older person's care needs including:
- services in and outside of aged care
- informal supports, what family, friends and neighbours contribute (including the sustainability of these)
- General recommendations include responsibility to action (older person/other).
- In some instances, Aboriginal and Torres Strait Islander assessment organisations may also be an aged care provider. It is critically important that clients are provided with choice and control over service providers from whom they would like to receive aged care services. Assessors should discuss all the options with the older person.

5.12.2. Setting the 'service seeking' preference for prioritised services under the Support at Home program

Access to ongoing Support at Home (SaH) classifications and AT-HM under the Support at Home program (the AT-HM scheme) is managed through three independent priority systems:

- the Support at Home Priority System – for the ongoing SaH classifications
- the Assistive Technology Priority System – for AT under the SaH program
- the Home Modifications Priority System – for HM under the SaH program.

As part of the assessment process, it is important for assessors to have a clear conversation with the individual about whether they are seeking to receive these services through the Support at Home program.

There is a separate 'seeking services' preference field in the Support Plan section of the Assessor Portal for each of these recommendations (ongoing SaH classification, AT and HM). Assessors must record if the client is 'seeking services' or 'not seeking services' through the Support at Home program for each of the recommendations, in line with the following guidance:

- For clients seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'seeking services'. This ensures that the older person is placed on the appropriate priority system(s).

- For clients not seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'not seeking services'.
- This option makes sure the client **does not** enter the relevant priority system(s) and will not be allocated funding under the Support at Home program. Relevant circumstances include when:
    - the client has chosen to access services through NATSIFACP or MPSP and so they do not require services from a SaH provider (or funding from the SaH program)
    - the client does not want to access the recommended services at this time.

If the older person later wants to access one of these services through the Support at Home program, they can change their preference and enter the relevant priority system. Older people wanting to enter the AT or HM Priority System will need to be a Support at Home participant (for ongoing home support) to do this. For all three priority systems, wait time is always counted from the original access approval date of effect. That is, for older people who enter any of these priority systems at a later time, it will be as if they had stayed in the queue from their first approval.

An older person can change their service seeking preference by:

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

5.13. Review of Support Plan

A review date can be entered on the Support Plan and reason for the review such as for "12-month review for CHSP ongoing service recommendation". Linking support and reablement start and end dates and review dates are displayed on the Support Plan. The 'Associated People' section of the Support Plan helps assessors identify the people who will be helping the older person meet their goals, or who may be providing support. It also assists in checking whether the older person consents to the associated person receiving their Support Plan.

5.13.1. Scheduling a Support Plan Reviews for Aboriginal and Torres Strait Islander assessment organisations:

Acknowledging that it may take a longer time to accurately identify the holistic aged care needs of an older Aboriginal and Torres Strait Islander person, following an initial assessment, an SPR should be scheduled to ensure the Support Plan remains responsive to the client's needs at the time of the assessment. The date should be:

- no later than 12 months after the assessment, and
- sooner if appropriate.

This approach enables the older person to access aged care services while enabling adjustments to the Support Plan if more needs are identified over time (most likely identified by the service provider) at the review date.

5.14. Assessment wrap-up

At the end of the assessment, an assessor should inform the older person of the next steps so they have a realistic expectation of what will occur following the assessment. This will help the older person to feel more assured and increase their satisfaction in the overall assessment experience. There are a variety of resources an assessor might leave with an older person at the conclusion of an assessment that are also available in many languages other than English (see Chapter 13. Aged Care Resources for Consumers).

An assessor must:

- Inform the older person on the next steps, such as:
    - who to contact and in what instance (e.g., if the older person has chosen to be referred to service providers, they will be contacted by these providers to discuss details of the service being requested; if the older person has chosen to receive a referral code, they will need to take the code to the provider of their choice to access the service)
    - the actions they, or others identified in the Support Plan, are responsible for (e.g., visiting providers, organising a check-up with a GP/specialist)
    - identify the older person's preferred referral method to action service referrals to providers and specialist assessment (e.g., allied health, occupational therapy assessment or vision services)
- Consider the older person's information preferences (e.g., hardcopy or electronic copy) and their communication needs.
- Provide contact details to the older person on who they should contact in the future [e.g., the My Aged Care Contact Centre, the assessment organisation (name and contact details of the assessor), and one or more service providers].
- explain that the assessor recommendations will be submitted to the assessment delegate for approval and the older person will be contacted about the outcome.

5.14.1. For Aboriginal and Torres Strait Islander Assessment Organisations:

Due to the higher likelihood of older Aboriginal and Torres Strait Islander people being vulnerable and require additional support to access services, it would be best practice to follow up with the client (or support network) post assessment as a matter of routine, particularly for those who:

- have complex social need;
- have limited family or community support;
- have experienced recent changes in health, housing, or care arrangements;
- have communication or cognitive difficulties that may impact understanding of the assessment;
- have referrals rejected/not actioned;
- have experience difficulties with accessing services;
- work on short-term goal(s) in line with the length of time stipulated in the Support Plan;
- need linking support and require short-term linking assistance for the purpose of implementing the Support Plan;
- have expressed uncertainty or concern about the process or services recommended; and/or

- are at risk of disengaging from services due to past negative experiences or systemic barriers.

Follow up may include, but not limited to:

- monitoring of referrals to services or negotiating with service providers for the provision of alternative services if necessary;
- discussion with the service provider and give advice to client on any follow up actions taken; and/or
- explaining any notifications/notices the older person may have received from MAC.

Resources | My Aged Care

5.14.2. Providing an assessment report for approval

Once the assessor has finalised the assessment, they must submit it for approval by an assessment delegate. For a comprehensive assessment, this delegate approval can be done on system. For home support assessments, this delegate approval workflow will be offline. A fact sheet is available to assessors and assessment organisations to manage this workflow.

Under the *Aged Care Act 2024*, assessors are required to provide the System Governor with a report of the assessment as soon as practicable after the assessment has been completed. This report is the support plan. System Governor functions at this stage of the assessment process are performed by (delegated to) Assessment Delegates. The assessor portal will support assessors to recommend the following to the assessment delegate for approval:

- **service groups**,
- the **classification type** (short-term, ongoing or hospital transition) for each recommended service group;
- the **classification level**
- any **service types** or **services**
- the **priority category** if required.

Assessors must also include in the support plan any information to support the Assessment Delegate to decide that the individual meets the relevant criteria (in the Act and its related rules) for the recommended approvals.

Assessors must ensure all information generated during the assessment is uploaded to the older person's My Aged Care Record following the completion of an assessment.

The fact sheet on non-clinical delegate workflow will be provided in the next addition of the Assessment Manual.

6. Chapter 6: Aged care programs

What you'll find in this chapter

This chapter includes important information about the aged care programs that can be recommended by assessors to meet an older person's assessed needs and goals. It includes information about:

- Support at Home (Ongoing 1 – 8)
- Support at Home (Restorative Care Pathway)
- Support at Home (End of Life Pathway)
- Support at Home (AT-HM)
- Commonwealth Home Support Program (CHSP)
- National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)
- Multi-Purpose Service Program (MPSP)
- Transition Care Program (TCP)
- Permanent residential care
- Residential respite

6.1. Support at Home - ongoing classifications 1-8

Support at Home improves on the four Home Care Package levels and consists of 8 ongoing classifications (1 – 8) with increasing levels of funding based on varying need in terms of the frequency and intensity of those services.

For participants assessed from 1 November 2025, a new classification framework will specify different funding levels based on the information captured during their assessment.

Funding amounts for each Support at Home classification are outlined below. Note that these amounts include the funding for care management, are indicative and are subject to indexation revisions.

In addition, there are 3 short-term pathways which are part of the Support at Home program, and these are defined as stand-alone service groups under the Act:

1. Restorative Care Pathway
2. End-of-Life Pathway
3. The Assistive Technology and Home Modifications (AT-HM) scheme

Table 24. Budgets for Support at Home classifications

Classification	Quarterly Budget	Annual Amount
1	$2,682.75	$10,731.00
2	$4,008.61	$16,034.45
3	$5,491.43	$21,965.70
4	$7,424.10	$29,696.40
5	$9,924.35	$39,697.40
6	$12,028.58	$48,114.30
7	$14,537.04	$58,148.15
8	$19,526.59	$78,106.35
Restorative Care Pathway	$6,011.04 (up to 16 weeks) May be increased to $12,000 when eligible and if units of funding are available	
End-of-Life Pathway	$25,035.36 (up to 16 weeks)	
Assistive technology short-term (12months)	Low ($500), medium ($2,000) and high ($15,000) funding tiers based on assessed need. A higher amount maybe approved with a valid prescription from a suitably qualified health professional. For progressive condition bundles, funding is available for 24 months (may be extended for another 24 months if required with declaration).	
Assistive technology On-going	Assistance dogs $2,000 per year	
Home modifications Short-term (12 months)	Low ($500), medium ($2,000) and high ($15,000) funding tiers based on assessed need.	

Classification	Quarterly Budget	Annual Amount
	Providers may apply for a funding tier time extension of an additional 12 months for HM high tier (24 months in total).	

A participant's annual Support at Home budget is divided into quarterly (3-monthly) budgets. Older people receiving Support at Home (known as participants) can carry over unspent funds of up to $1,000 or 10% of the quarterly budget (whichever is greater) from one quarter to the next.

These budgets are segmented into quarterly allocations to provide tailored support based on the participant's classification.

Ten percent (10%) will be deducted from each participant's quarterly budget for care management delivered by their service provider. Care management involves:

- planning and coordinating services
- checking in with participants to ensure they are being well supported
- clinical advice and practical support to address any changes in need or issues that arise
- providing support and education where needed.

Support at Home Program Manual

An Assessor's Role in budget planning and contributions

Assessors are not expected to develop detailed budget plans or explain contributions with Support at Home participants. The assessor may wish to give a high-level overview based on the information in this guidance document and direct their client to the Support at Home fee estimator tool.

A full fee estimator is available via the department's website myagedcare.gov.au/support-at-home-fee-estimator. This tool will allow people to plan budgets and estimate their contributions.

The assessor should emphasise that there will be an opportunity to discuss contributions further with their registered provider's care partner. A budget must be developed between the participant and their provider alongside the development of the care plan. The budget must outline how funding for participant's ongoing and/or short-term services will be spent in relation to the types and frequency of services outlined in their care plan, as well as any contributions for services to be delivered.

6.1.1. The Support at Home Priority System

An older person approved to access ongoing Support at Home services (SAH classifications 1 to 8) will enter the Support at Home Priority System in one of its four priority categories:

- Urgent
- High
- Medium
- Standard

An older person's priority category is based on the information collected during the aged care needs assessment. It is automatically calculated using the responses to six different criteria. The amount of time the older person waits to receive their funding will depend on the priority category they are given. The priority category will be displayed under 'Approvals for a Client' in the Assessor Portal.

If an assessor makes changes to the following fields in an older person's client profile after the priority category has been calculated and the person has been placed in the queue, the system will automatically recalculate the priority category and queue position:

- Accommodation type
- No fixed address
- Lives with
- Aboriginal and Torres Strait Islander Status

An older person can request to be set as 'seeking services' or 'not seeking services' at any point. This can be done by contacting My Aged Care, or by using the My Aged Care Online Account.

6.2. Support at Home - Restorative Care Pathway

The Restorative Care Pathway (RCP), under the Support at Home program, is designed to provide early intervention support to older people by:

- preventing or delaying the need for ongoing in-home care services or the need to access higher levels of ongoing care
- supporting participants to regain their ability to carry out daily activities
- helping participants to manage new or changing age-related conditions
- providing reablement education and skills to participants on how they can retain better function as they age for longer independent living.

The RCP can be provided in a home or community setting, or a combination of both. An older person can receive up to a maximum of two units of RCP in any 12-month period. The RCP cannot be undertaken consecutively and must allow a minimum 90-day period between episodes.

The RCP can be delivered for up to a duration of 16 weeks. Participants may have a shorter RCP episode, for example, where they reach their goals earlier.

The RCP may also be accessed in addition to a participant's ongoing Support at Home budget. A participant with an ongoing Support at Home budget who is approved for RCP, can continue to access their ongoing services while undergoing the Restorative Care Pathway. Restorative care partners will need to ensure that services are complementary.

Important:

An approval for RCP is equal to 1 unit of RCP funding (approximately $6,000). RCP units are capped to 20,000 units of funding annually (managed as 5,000 units of funding per quarter) across Australia.

From 1 November 2025, system-based visibility of RCP caps will not be available. As a result, there will be no in-system prompts or controls to prevent the approval of RCP units beyond the quarterly caps.

Twice-weekly reports of allocations will be generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

Assessors and Assessment Delegates should remain aware of any communication from the Department's Assessment Delivery Section regarding RCP units. This will apply to decisions made through assessment/reassessment and SPRs.

6.2.1. Assessing for the Restorative Care Pathway

RCP provides a coordinated, multidisciplinary package of allied health and/or nursing services. An individual must require a range of different allied health and/or nursing interventions to be eligible for the RCP. For example, an individual only requiring physiotherapy, domestic assistance and gardening is not eligible as they do not meet the requirements for a multidisciplinary allied health and/or nursing team.

Supporting people to regain independence and function to facilitate less reliance on higher levels of care is a critical objective of RCP. The intent of the RCP is not for an older person to receive passive 'care' services but to be an active participant to safely regain lost independence based on their individual circumstances.

A reablement approach underpins the Support at Home RCP, aiming to restore capability and keep people as independent as possible.

A person is eligible to receive RCP only if they meet all of the following criteria:

- The person is assessed as experiencing functional decline that is likely to be reversed through frequent, multidisciplinary allied health and/or nursing interventions over a short period of time
- The person has goals which align with restorative care outcomes (improve function, want to be independent, rely less on others' help, regain previous levels of function, etc)
- The person demonstrates motivation through willingness and capacity to engage and actively participate in short-term clinical interventions to increase

independence (for example, willing to attend frequent allied health appointments, engage in exercise and/or nutrition classes, learn how to apply techniques to regain independence, increase health literacy and education, etc)

- The person has received an ongoing SaH classification through the IAT Outcome (please see note below)
- The person is not receiving or, eligible for, the Transition Care Program (they should also not be in hospital at the time of assessment)
- The person is not in permanent residential care
- The person is not eligible for, or has recently received, the End-of-Life Pathway
- The person has not been approved for more than two units of RCP funding in any 12-month period and/or at least 90 days have passed from the end of the 16 weeks period associated with the original episode.

Assessors must only recommend the RCP if all the above eligibility criteria are met.

Assessors may consider contacting the older person to discuss alternative supports for recommendation if the RCP units are near exhaustion.

Case Study: Omar, age 66

Omar is 66 and lives with his wife, Barbara. He recently had a little fall which has left him with a few small issues but has severely impacted his confidence. He is after some help around the home, so he doesn't fall again. After talking to both Omar and Barbara, the assessor suggests he might like to consider Restorative Care Pathway (RCP)as:

- Omar still has quite good mobility but needs some help building up his balance and strength to restore his confidence.
- Omar has the support of Barbara and family who are keen to help him stay independent.
- Omar initially had some concerns about undertaking the RCP but after discussion with the assessor, he is willing to try it as he would like to remain independent at home.

Omar's restorative care provides:

- Biweekly strength classes which start as individual classes at Omar's home with an exercise physiologist but, as his confidence increases, transitions into group exercise classes at the allied health centre. This also provides opportunity for Omar to connect with others while supporting increases in physical and mental function.
- Nutritionist support which provides insight and education into nutritional requirements to support his increased activity and support good health (plus meeting any cultural food requirements).
- Two podiatrist appointments to assess for issues with his feet which are impacting his balance.
- A restorative care partner who works with him on his goals and continues to support Omar, checking in periodically, monitoring his progress and continuing to discuss how problems achieving his goals can be resolved to help restore his confidence with the multidisciplinary team (MDT).

Outcomes

Omar regains confidence in his mobility. He teaches Barbara what he learns during his time receiving RCP services. They start attending strength building classes together at the local gym and join a walking group. After discussion with Omar and Barbara, the exit plan recommends no ongoing services are needed.

Case study: John, age 55

John is a 55 year old Aboriginal man. He currently receives Support at Home classification 1 to help support him at home. He has several chronic health conditions and lives with his wife and adult son. His GP has recommended he be reassessed to help him manage his health conditions. After yarning to John and his family, the assessor recommends the Restorative Care Pathway (RCP). This is because services and education on how he can remain independent at home could help the household which is a good outcome for everyone. John knows he can manage his health conditions if given the support to do so.

His goals support restorative care outcomes (to regain function, keep level of independence, delay needing higher level of services). John was also approved for assistive technology and home modifications funding to support his RCP episode. This is funded through the Assistive Technology-Home Modifications (AT-HM) scheme.

Delivery

John's restorative care provides:

- Support and referrals to help manage his health issues including to a care manager at the local primary health network for his diabetes
- Support from a registered nurse who provides education and advice around how John can manage his health conditions.
- An occupational therapist (OT) visits several times to talk to John and his family about what assistive technology and home modifications can help him and, how John and his family can use the assistive technology safely and to check that home modifications meet John's needs.
- Administration and coordination costs of sourcing relevant AT-HM to support his restorative care goals.
- An Aboriginal and Torres Strait Islander Health Worker works with John to help provide cultural support, treatments and conduct relevant health assessments and provide connection to other relevant services, as required.

John's ongoing Support at Home services continue. A restorative care partner helps ensure restorative care services complement his ongoing Support at Home services.

Outcomes

John's restorative care partner finalises the exit plan after reviewing the goals identified in John's goal plan. John feels that he can apply what he learnt about managing his conditions, deciding he was happy with his current level of ongoing support. His RCP episode ceases and his ongoing Support at Home services continue.

6.2.2. Expectation setting

Expectation setting is an important part of ensuring restorative care is successful and helps ensure people receive the care they need. Assessors should ensure the roles, responsibilities and objectives of RCP are fully explained during the assessment (including in comparison to ongoing care). This should happen before the RCP is recommended to ensure the older person fully understands the support that will be

available to them and their role. Older people who do not have the capacity or the willingness to engage with the RCP should not be recommended and approved for it.

For older people new to the aged care system and who are not receiving aged care services:

- an ongoing Support at Home or CHSP classification cannot be recommended at the same time as the RCP.
- the RCP is not a mechanism to access urgent services.

For older people who are receiving aged care services through an ongoing classification:

- The RCP can be recommended and approved where eligibility criteria **are** met.
  - Assessors must consider the potential for functional improvement that would delay the need for a higher-level classification when approving RCP (as a higher ongoing Support at Home classification cannot be recommended at the same time).
  - The RCP is not a mechanism to provide additional funding to supplement ongoing services.

- If, through a reassessment, the IAT outcome is a higher ongoing classification, assessors will only be able to select the higher ongoing classification OR the RCP.
  - If the RCP is selected, the person will remain on their current ongoing classification (rather than the higher classification recommended).

- Assessors should consider if the older person's current provider delivers the RCP.
  - Under Support at Home, services must be delivered by a single provider (service delivery branch level). If the provider does not deliver the RCP, the participant will need to change providers to access both RCP and ongoing services. This should be considered before approving the RCP for people already accessing ongoing services through Support at Home.

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

For new participants, eligibility for ongoing services will need to be determined at the end of the RCP episode (if RCP is recommended).

6.2.3. Recommending Restorative Care Pathway in the assessor portal

Upon finalisation of the IAT, if the IAT outcome recommends an ongoing Support at Home classification, this can be overridden to change the IAT outcome to the RCP by clicking the override button. By overriding to the RCP, assessors will be navigated to the '*Add Home Support Services*' page to add services.

Note:

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

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

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

Older people approved for the RCP can only access services they have been approved for.

Assessors should consider what services are being accessed under the person's ongoing Support at Home classification and ensure they are complementary (and be based on need connected to their restorative care approval). Assessors should note that delivery of multidisciplinary intensive allied health/nursing services is a key element of the RCP.

Restorative care management is also a mandatory service type when undertaking the RCP. To search for a RCP provider, people can search for the service type 'restorative care management' through the 'Find a Provider' website (when 'Support at Home program' is selected.

Note: Hoarding and Squalor services cannot be recommended alongside a recommendation for the Restorative Care Pathway.

6.2.4. Interactions with other programs

Table 25. Restorative Care Pathway interaction with other programs

Program	Interaction with Restorative Care Pathway (RCP)
Ongoing Support at Home	If an older person receives an ongoing Support at Home classification through the IAT, this can be overridden to recommend the RCP. An approval for an ongoing Support at Home classification will cease an active RCP episode.
Assistive Technology and Home Modifications (AT-HM) scheme	Older people approved for the RCP may also require Assistive Technology or Home Modifications to support good restorative care outcomes. Assessors must always ensure these needs are considered when approving the RCP. Older people who are approved for the RCP are eligible to receive an Assistive Technology low, medium and high funding tier, and low and medium tier **home modifications**. Participants with an ongoing Support at Home classification who are already have high

Program	Interaction with Restorative Care Pathway (RCP)
	tier home modifications funding can keep this approval, noting this approval is connected to their ongoing classification approval. The assessor will need to select assistive technology and home modifications for these to be added to the support plan.
CHSP	Though the IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment, an assessor must **not** recommend or approve the RCP for: • an older person new to the aged care system and not receiving aged care services, who is recommended CHSP by the IAT outcome; or • an older person already accessing CHSP, who is recommended CHSP by the IAT outcome. (Noting, where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.) If an older person accessing CHSP is recommended an ongoing Support at Home classification through a reassessment using the IAT, this can be overridden to recommend the Restorative Care Pathway. Note: Older people can access allied health and therapy services through CHSP. Assessors can recommend reablement and/or allied health and therapy services on their support plan
End-of-Life Pathway (or if they have recently accessed this pathway) Transition Care Program Permanent Residential Care	Cannot receive the Restorative Care Pathway at the same time (applicable for EoL, TCP and permanent Residential Care).

6.2.5. Lapse in Restorative Care Pathway access

Access to the Restorative Care Pathway (RCP) will lapse if:

- the older person's episode of RCP ends (maximum 16 weeks); or
- a person does not enter into an agreement with a provider to deliver the RCP before the access code expires (within 56 days of approval with a further 28 days if My Aged Care is contacted for an extension).
- an assessor delegate approves an ongoing Support at Home classification (including higher ongoing Support at Home classification) while the person is still accessing the Restorative Care Pathway.

Note:

Assessors should check if the older person is accessing the RCP and ensure the older person is aware approval for an ongoing Support at Home classification will end their RCP episode.

An older person will need to be reassessed if they wish to access the RCP after their access period ends lapses (with a 90 day break applied).

6.2.6. Manual oversight of Restorative Care Pathway places

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

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

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

- This cohort will also be accessing the RCP units of funding for the first six months from 1 November 2025.
- A second unit of funding to use within a single RCP episode can be requested via a Support Plan Review (SPR) request. However, assessors will need to self-refer this for reassessment to grant access to a second unit of funding. This is because the ability to add a second unit via SPR will not be available on the assessor portal for those with an STRC approval.
    - The reassessment can be done over the phone and does not require queuing for a face-to-face assessment.
    - The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request.
    - Availability of RCP funding units may also be considered.
- When a request for a second unit of RCP is received assessors should confirm if there is approval for STRC and RCP on the client's record. If there is approval for both, the assessor will need to confirm with the client if the client entered care

under the RCP after 1 November 2025 using the STRC approval. If this is the case, then the assessor must not approve a third unit of RCP funding.
- If the participant is eligible to access an additional RCP unit they must wait at least 12 months before accessing another episode.

Assessors will need to remain acutely aware of any communication from the department regarding RCP caps to ensure you are making informed decisions. These communications will be the **primary tool** for identifying when RCP units are nearing exhaustion. Being responsive to these insights is essential for maintaining compliance with pathway limits and avoiding over-allocation.

Before recommending the RCP for approval, assessors should consider whether other service types—such as other Support at Home services or reablement options under the Commonwealth Home Support Program (CHSP)—could provide an equivalent level of support. This ensures that recommendations for approval are appropriate to an individual's needs, consider if a place will be available for the older person to access, and aligned with the sustainable allocation of places.

If a RCP recommendation is not made due to no places being available for allocation, the assessor should consider discussing with the older person alternative supports for recommendation. Assessors may also consider if an alternative classification could be recommended to meet the care needs of the individual.

6.2.7. Restorative care funding

The RCP provides around $6,000 of funding, for up to 16 weeks. The total amount of funding a participant uses and length of time to complete an episode can differ. Restorative care partners will consider this when developing the goal plan.

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode. If the participant requires additional funding within a single 16-week episode, the provider can submit a request for a Support Plan Review. If certain circumstances are met, approval can be given for the additional $6,000 in funds to support the episode (see Chapter 10 on Support Plan Reviews).

If approved, a participant can access an additional unit of funding (up to $6,000), to provide a combined total of up to $12,000, for a single RCP episode. If additional funding is approved, a participant will not be eligible for a further episode of RCP within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

The decision to approve additional funding to the RCP episode is made under *subsection 195-3 of the Rules*. It is a non-reviewable decision. The criteria in the Rules includes that required evidence must be given by the participant's provider and there must be units of funding available for approval.

Evidence to support the additional funding may include:

- Goal plan and individualised budget outlining how the required clinical interventions are not supported by the initial funding
- Information as to why ongoing funding cannot be used to complement restorative care clinical goals.

The assessment delegate must send a letter to the older person (and their registered supporter/s, if required under the Act) notifying them of the outcome of the application for the additional funding. The assessment delegate should choose the appropriate template under 'Reports and documents' > 'Forms' in the Assessor Portal.

Note: This is a different template to the Notice of Decision issues for other approval decisions.

6.2.8. Restorative Care Pathway and the Support at Home Priority System

The Restorative Care Pathway (RCP) is not subject to the Support at Home Priority System. People can access RCP once a Notice of Decision letter has been received after delegate approval. Please note that selecting the RCP will mean that any new ongoing or higher ongoing Support at Home classifications cannot be selected. As such, assessors should consider long term need when approving for the RCP. An assessor may only select an ongoing (or new ongoing) Support at Home classification which will put them in the Priority system OR select RCP.

RCP participants will have immediate access to any recommended assistive technology and home modifications under the AT-HM scheme based on their assessed needs.

6.2.9. Hospitalisation, residential respite and leave

People may need to enter hospital or residential respite while accessing the RCP. There are no leave provisions under Support at Home. If a person's RCP episode finishes while they are in hospital or residential respite, they will need to consider reassessment to determine what will meet their needs.

6.3. Support at Home - End-of-Life Pathway

The End-of-Life Pathway is one of the short-term home support classifications under the Support at Home program. A participant can access one episode of the End-of-Life Pathway. A total of $25,000 is available per eligible participant over a 12-week period. This is the highest funding classification category (per day) available in the Support at Home program.

An older person is eligible to access this pathway if they meet the following criteria:

- A doctor or nurse practitioner advises an estimated life expectancy of 3 months or less to live
- Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less.

Funding can be used to access the participant's approved services from the Home Support service list, including care management.

6.3.1. End-of-Life Pathway form

The End-of-Life Pathway form is used to document the required medical evidence for accessing the End-of-Life Pathway under the Support at Home program. An individual seeking access to the End-of-Life Pathway must complete all relevant sections and present this form to a medical practitioner or nurse practitioner for completion. The completed form should then be submitted as part of the assessment process—either before or during triage, or assessment—and reviewed to confirm eligibility for the End-of-Life Pathway.

Assessment delegates are responsible for verifying the completion of this form in the older person's record when the End-of-Life Pathway has been flagged in the My Aged Care assessor portal.

Reviewing the form will involve:

- Checking the individual's details to ensure they match the record in the portal.
- Verifying the completion of all areas of the Medical Assessment section to confirm:

  1. The individual has a prognosis of a life expectancy of three months or less, and
  2. An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
  3. Medical practitioner or nurse practitioner has completed and signed the form.

An individual will **not** be eligible for approval for the End-of-Life Pathway if the required criteria outlined in the medical assessment section are not met.

6.3.2. Accessing the End-of-Life Pathway

Existing Support at Home participants can access End-of-Life Pathway through a **Support Plan Review.** This is usually requested through the My Aged Care Service and Support Portal by the older person's provider and should be made using the approved form.

Older people can seek a referral through their medical practitioner or other health professional (using the Make a Referral or GP e-referral channels) or by contacting the My

Aged Care contact centre or using Apply Online. The End-of-Life Pathway form must be attached for referrals using Make a Referral or GP e-referral. For other entry pathways, Triage is still able to be undertaken without a completed End-of-Life Pathway Form. In these instances, participants should be advised at Triage to have the form completed by an appropriate medical practitioner (their GP, non-GP specialist or nurse practitioner.) The End-of-Life Pathway Form must be completed before the End-of-Life Pathway is approved.

Once approved, services are delivered under the End-of-Life Pathway classification and care partners work with any relevant state and territory palliative services to ensure care is appropriate and tailored to the individual's preferences and needs.

6.3.3. Interactions with other programs

Table 26. End-of-Life Pathway interactions with other programs

Program	Interaction with the End-of-Life Pathway
Assistive Technology and Home Modifications (AT-HM) scheme	Individuals receiving support through the End-of-Life Pathway can be approved to access assistive technology (Tier 1 or 2 only) at the same time. If approved for assistive technology, immediate AT-HM scheme funding can also be used to access products and equipment from the AT-HM list. If eligible, primary supplements will also apply to participants. The assessor will need to select assistive technology for this to be added to the support plan. Access to home modifications is not permitted. If home modifications are already underway through the AT-HM scheme at the time the End-of-Life Pathway is approved, these modifications can continue while accessing the End-of-Life Pathway.
Residential Respite	Participants accessing the End-of-Life Pathway may continue to access these services during a period of Residential Respite, as long as services are not duplicative.
Transition Care Program	Participants accessing the End-of-Life Pathway are not eligible to receive transition care.
CHSP	Participants accessing the End-of-Life Pathway can access CHSP services, including urgent services, in limited circumstances. See Table 29 for more information.

Program	Interaction with the End-of-Life Pathway
Support at Home ongoing	
Restorative Care Pathway	An individual cannot access these services under the End-of-Life Pathway
Permanent Residential Care	

If an individual is eligible for the End-of-Life Pathway, they can be referred and transitioned out of any of the above programs to begin receiving services under the End-of-Life Pathway. Individuals who are accessing services through MPSP or NATSIFACP, can access their SAH End-of-Life approval through those programs as well. Participants accessing the End-of-Life Pathway may continue to access these services during a period of Residential Respite, as long as services are not duplicative.

6.3.4. Funding for the End-of-Life Pathway

Funding for the End-of-Life Pathway is discrete from other Support at Home classifications. If an existing Support at Home participant moves to the End-of-Life Pathway, this will replace their ongoing Support at Home classification.

Unlike an ongoing classification, participants cannot accrue funds under the End-of-Life Pathway. This means that any unspent budget from an End-of-Life Pathway classification will not follow a participant if they live beyond the End-of-Life funding period and move to an ongoing classification.

Transitioned HCP clients can access the End-of-Life Pathway via an SPR, like all existing Support at Home participants. If they require services beyond the End-of-Life Pathway funding period, they can return to their previous transitional classification via an SPR.

6.3.5. Allocation of ongoing Support at Home to the client after End-of-Life Pathway

If the participant requires ongoing Support at Home services following the completion of the End-of-Life Pathway, the following will apply:

Participants who were accessing ongoing Support at Home services prior to accessing the End-of-Life Pathway can be transferred to their previous Support at Home classification via an urgent Support Plan Review.

Participants who were new to Support at Home when they commenced the End-of-Life Pathway can be transferred to the inactive classification that was assigned at their aged care assessment, via an urgent Support Plan Review.

6.3.6. Assessing for End-of-Life Pathway

When assessing for the End-of-Life Pathway, only mandatory questions that are required to run the IAT Outcome and generate an ongoing Support at Home classification are required to be completed. This is to ensure the older person has a valid classification to return to if they need services beyond the End-of-Life Pathway funding period. Other questions are optional based on the individual's needs and context.

6.3.7. Recommending the End-of-Life Pathway in the assessor portal

Assessors can select the End-of-Life Pathway for older people under the *'Goals & recommendations'* tab within the Support Plan and services section of the My Aged Care Assessor Portal. It is best practice for End-of-Life to be flagged and verified prior to the commencement of the assessment, however there are allowances to be able to complete these two tasks after an assessment has started.

Upon finalising the IAT, the system will recommend either a single CHSP classification or an ongoing Support at Home classification (in nearly all instances, it will be a Support at Home classification for this cohort). If a Support at Home classification is generated, assessors will need to override the recommendation and choose 'End-of-Life'. Assessors will be navigated to the 'Add Home Support Services' page where services are pre-selected. Assessors should only unselect service sub types if they think the client may not have a need for this service.

This will then enable assessors to allocate this pathway for assessment delegate approval.

6.4. Support at Home – Assistive Technology and Home Modifications (AT-HM) scheme

The Assistive Technology and Home Modification (AT-HM) scheme is a short-term pathway that supports older people to live at home and within their community with increased independence, safety, accessibility and wellbeing. The AT-HM scheme provides separate supports under Support at Home, with separate funding tiers (called *classification levels* under the Act) and program settings. Participants can access both assistive technology and home modifications funding tiers at the same time if needed. This will provide upfront funding to access products, equipment and home modifications. The AT-HM scheme is delivered in parallel to a participant accessing ongoing services through Support at Home. This means that participants can access these supports without needing to save up funds from their Support at Home quarterly budgets for ongoing services.

6.4.1. AT-HM scheme participants

AT-HM scheme participants are empowered to actively participate in informed decision-making regarding the care, products, equipment and home modifications they receive. Providers are expected to consult participants to determine their support needs to ensure services are individualised and relevant.

Through the AT-HM scheme, participants will:

- have access to the AT-HM list to understand what equipment, products and home modifications are available to meet their assessed need,
- actively participate in the care planning process and have the AT-HM scheme explained in a way that they understand,
- identify their needs, life goals, strengths, and service delivery preferences including choice of health professionals,

6.4.2. Assistive technology

Assistive technology (AT) is any item, piece of equipment or product that is used to help an older person do things more easily or complete activities they can no longer do independently.

Examples of assistive technology include:

- mobility equipment such as walking sticks, walking frames and wheelchairs
- toileting supports including bedpans and commodes
- bathing devices including shower chairs and bath boards
- alternative and augmentative communication (AAC) products
- products for food preparation and eating including adaptive cutting boards and knives, as well as modified cutlery
- costs associated with assistance dog maintenance.

The AT-HM scheme does not include items such as:

- everyday household appliances e.g., a dishwasher
- assessment or therapy tools used by a therapist
- products or technologies funded through an alternative national or state-based program (e.g., the Medical Aids Subsidy Scheme).

Assistive Technology and Home Modifications list (AT-HM list)

6.4.3. Home modifications

Home modifications (HM) provide changes to an older person's home to create a home environment that is safer and more accessible, so they can remain living safely at home.

Examples of home modifications include:

- lever tap sets or lever door handles

- grab rails in the shower or bathroom
- internal and external handrails
- modified door locks
- non-slip materials and surfaces for floors and stairs.

In some circumstances, participants may be approved for more significant home modifications including:

- bathroom modification (e.g., level access shower and modifications to improve accessibility)
- ramps and stairlifts.

The AT-HM scheme does not include:

- general renovations to a home or dwelling
- restorations or repairs which are considered normal maintenance of home or dwelling
- changes to a home layout that do not relate to a participant's support needs.
- AT-HM funding tiers.

6.4.4. Funding tiers for AT-HM

The table below outlines the 3 funding tiers for assistive technology and home modifications.

Table 27. AT-HM funding tiers

Funding tier	Funding allocation cap	Funding period
Assistive technology		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000[1] (nominal)	12 months
[1] Products and equipment with costs greater than $15,000 are available to participants with a prescribed need.		
Home modifications		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000	12 months[2]
[2] Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence is provided to Services Australia		
Other funding		
Assistance dog maintenance	$2,000 per year	Ongoing[3]
[3] Funding for assistance dog maintenance will be automatically allocated every 12 months; however, the funding cannot accrue or rollover.		

This funding may cover the following:

- Assistive technology equipment and products
- Repairs or maintenance of assistive technology items available on the AT-HM list
- Prescription of items, where appropriate, by a suitably qualified health professional working within their professional scope of practice
- Associated administration activities (cap will apply – see the AT-HM scheme guidelines for further details).

Participants will be allocated a funding tier for 12 months (in most cases) to spend their assistive technology and home modifications funding.

The cost of wrap-around services—such as delivery, setup, training, and follow-up—are also drawn from the AT-HM funding tier. Providers can add a 10% charge on administration costs for AT claims and a 15% charge for coordination costs for HM claims. Assessors must consider these costs when allocating a funding tier.

Participants may be required to contribute towards their assistive technology or home modifications.

AT-HM funds will not accrue over time and funding will be available for 12 months once a participant is assessed (or reassessed) and approved. If major home modifications take longer than 12 months, funding may be available for a further 12 months if the participant can provide evidence the work has commenced. This will ensure enough time to complete the work to the required standards.

Older people identified at assessment with specific progressive conditions may be eligible to access assistive technology funding for 24 months to meet their rapidly changing needs. The 13 conditions listed below are all eligible AT-HM progressive conditions under Support at Home.

These conditions are:

- Cerebral Palsy
- Epilepsy
- Huntington's Disease
- Motor Neurone Disease (MND) noting different phenotypes require different management
- Multiple Sclerosis (MS)
- Parkinson's Disease
- Late effects of Polio
- Spinal Cord Injury
- Spinal Muscular Atrophy
- Stroke
- Acquired Brain Injury noting different types of brain injury require different management
- Muscular Dystrophies and Muscular Atrophies.

In some cases, this funding can be extended for another 24 months, providing a total of 48 months of support. If available, Home Care Package unspent funds must be used to access assistive technology and home modifications before AT-HM scheme funding is used.

6.4.5. AT-HM list

The AT-HM list sets out the assistive technology and home modifications that can be accessed and funded through the AT-HM scheme.

The AT-HM list is sorted into the following categories:

- managing body functions – including pressure cushions, anti-oedema stockings and memory support products
- self-care products – including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- mobility products – including walking frames, wheelchairs and lifting devices
- domestic life products – including assistive products for food preparation, eating, drinking and house cleaning

- communication and information management products – products and equipment that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices
- home modifications - including accessible showers, grabrails, fixed ramps and safety barriers.

The AT-HM list also outlines the recommended prescription category for each item. The prescription category is the suggested level of skill or qualification required to effectively provide recommendations for the safe and effective use of assistive products or equipment or installation of home modifications.

Assistive Technology and Home Modifications list (AT-HM list)

6.4.6. Assessing for the AT-HM scheme

Existing questions in the IAT will help to identify and determine an older person's need for assistive technology and home modifications. The AT-HM tier guide will assist the assessor to make a funding tier recommendation. For example, the function section will provide a more detailed understanding of a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

Assessors are **not required** to determine the exact item or product to be provided. Rather, an assessor's role is to identify whether the person is likely to benefit from AT or HM supports based on observed and reported difficulties, risks, or goals. Assessors are asked to assign a funding tier for AT and HM based on the assessed need with the support of the AT-HM tier guide. It is recommended that assessors also familiarise themselves with the AT-HM list and how it is utilised in the AT-HM scheme. The specific types of AT-HM best suited to the client, and any required prescriptions, is the responsibility of the registered provider at the point of service delivery.

During the assessment, consider whether the older person:

- has needs and goals that could be met through using assistive technology and home modifications
- can have those needs met through the products, equipment and home modifications included on the AT-HM list.
- may require prescription or wraparound services for the assessed needs of the assistive technology and home modifications. This will need to be considered and captured under the recommended funding tier allocation.

6.4.7. AT-HM funding tier guide

If assessors identify that the older person requires AT-HM they are required to recommend a funding tier. AT-HM funding tier guidance has been developed to assist assessors to make a funding tier recommendation for AT and HM based on the older person's assessed need in the IAT. This includes considering their current functional ability and home environment.

The guidance has been designed to consolidate the main elements of the IAT relevant to AT-HM and support assessors in choosing a funding tier. The guide will suggest an

assessment tier which should sit where the majority of tier indicators have been selected. The guide groups indicators into three tiers: **Tier 1 (low), Tier 2 (medium), and Tier 3 (high)**—and uses a checkbox format for ease of completion. The AT-HM tier guide provides a non-scored pattern of recommendation—the more indicators selected within a particular tier, the stronger the alignment with that level of support.

Where the guide does not produce a clear outcome, or in more complex cases, clinical reasoning based on the person's functional ability, safety, independence, and home environment should guide the tier allocation. Progressive conditions—particularly if multiple are present—may also justify a higher tier allocation (e.g. Tier 3), even if fewer indicators are ticked.

Assessors should ensure their recommendations align with the participant's goals, safety, independence, and overall ability to remain living at home. They may choose to select an alternate tier if funding does not align with assessed need. Assessors can upload the document as an attachment to allow the assessment delegate to review as supporting evidence for any funding tier recommendations made.

Note:

Assessment operation managers will have access to the AT-HM tier guide document on the assessor SharePoint site. Operation managers can download and provide the template to assessors.

6.4.8. Instructions for assessors completing the AT-HM Tier Guide

The AT-HM Tier Guide should be used by assessors and assessment delegates to determine the appropriate funding tier for an older person who has been assessed as having a need for AT and/or HM.

Assessors are asked to complete the following:

- use the relevant information from the older person's assessment when completing the AT and HM tier guide
- select the relevant indicators on the tier guide for either AT and HM based on the older person's assessed need
- review the guide to support tier allocation recommendation. The AT-HM tier guide will suggest a tier where the highest number of tier indicators have been selected.
- upload the completed AT-HM tier guide to the assessor portal under 'other' and title the document 'AT-HM Tier Guide'. The Assessment Delegate should consider the guide when approving or declining the AT-HM funding tier.
- manually add the recommended AT and HM tier in the support plan once a funding tier is determined.

Assessment decisions for AT-HM funding tier allocation can be reviewed through a Support Plan Review if the funding tier does not cover the assessed need.

CASE STUDY: AT Tier 1 (low tier)

Carol is 65 and has just been assessed and during her comprehensive assessment it was found that she is managing daily activities independently but would benefit from some help with housework and getting to and from the shops. She mentioned that she has some difficulty washing her legs, feet and back in the shower and finds it hard to bend down to put her shoes on.

The assessor thinks Carol may benefit from some basic items such as a long-handled sponge, a non-slip bathmat and a long-handled shoehorn. After looking at the AT-HM list the assessor believes that all these items are low-cost and low risk and Carol should be allocated Assistive Technology Tier 1 (AT low tier) funding to cover the cost of these items.

Using the assessment findings the assessor completes the assistive technology section of the AT-HM tier guide. All selected indicators sit within Tier 1. The assessor allocates Carol with an Assistive Technology Tier 1 (AT low tier) on the support plan. This decision is supported by the information gained during the assessment and the AT-HM tier guide recommendation.

The assessor uploads the AT-HM tier guide to the assessor portal under 'other' naming the document 'AT-HM tier guide'. This is considered by the delegate as supporting evidence of AT-HM tier recommendation.

Carol's AT recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate, Carol will receive a Notice of Decision letter informing her that she has been approved for a SaH on-going classification and Tier 1 (AT low tier) funding for assistive technology. Once funding is assigned, she can then find a provider to help source the low-cost and low risk AT items she needs.

CASE STUDY: HM Tier 3 (high tier)

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

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

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

The assessor uploads the AT-HM tier guide to the assessor portal under 'other' naming the document 'AT-HM tier guide'. This is considered by the delegate as supporting evidence of AT-HM tier recommendation.

David's HM tier recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate, David will receive a Notice of Decision letter informing him that he has approval for a SaH on-going classification and Tier 3 approval for home modifications (HM high tier). Once funding is assigned, he can then find a provider to help source the prescriber and home modifications he needs. The Elder Care Support worker can assist David with this process. When this is explained to David, he says he is excited to think about being able to do shopping and other tasks for himself whenever he needs to. He is also glad this will take some of the pressure off his son.

CASE STUDY: Progressive Condition

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

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

The assessor uploads the AT-HM tier guide to the assessor portal under 'other' naming the document 'AT-HM tier guide'. This is considered by the delegate as supporting evidence of AT-HM tier recommendation.

Margaret's AT-HM tier recommendation is sent to the assessment delegate for approval. If approved by the assessor delegate Margaret will receive a Notice of Decision letter informing her of her new SaH on-going classification and AT-HM funding. She has been recommended AT Tier 3 (AT high tier) and HM Tier 2 (HM medium tier) funding approval and once funding has been assigned, she can then find a provider to help source the prescriber, assistive technology and home modifications she needs.

6.4.9. Recommending AT-HM tiers in the assessor portal

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

Assistive technology

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

Assistance dogs

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

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

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

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

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

Home modifications

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

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

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

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

6.4.10. AT-HM Scheme Priority System

The AT-HM scheme has a separate priority system to the Support at Home Priority System. The AT-HM scheme has an Assistive Technology Priority System and a Home Modifications

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

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

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

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

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

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

6.4.11. Interactions with other programs

Table 27. AT-HM Scheme interactions with other programs

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

Program	Interaction with the AT-HM scheme
Residential Respite	Can receive AT-HM in their home while in respite
Transition Care Program	TCP clients who have an on-going Support at Home classification will be eligible for the AT-HM scheme under Support at Home. TCP clients who are *not* currently on a Support at Home package will be able to access AT through TCP.
CHSP	Participants who are not eligible for Support at Home that require low level on-going services as well as assistive technology and/or home modifications will receive a CHSP classification. These services will be delivered under a CHSP AT and/or HM classification.
Permanent Residential Care	Cannot access AT-HM

6.5. Commonwealth Home Support Program (CHSP)

From 1 November 2025 the CHSP comes under the *Aged Care Act 2024* and there will be changes to the way that CHSP services are regulated and delivered. This means the types of services delivered must only be provided to older people who are eligible and have had their care needs assessed care. The CHSP service catalogue 2025-2027 details the services an eligible person can receive under CHSP. CHSP will be transitioned into the Support at Home Program no earlier than 2027.

The service list for CHSP has changed and been updated for delivery of services in the period between 2025 and 2027. See the below service catalogue for further information.

The CHSP is a grant funded program which provides entry-level support to help older people continue to live safely and independently at home and in their communities. It is available to people who meet the eligibility requirements under section 58 of the *Aged Care Act 2024*. The CHSP is suitable for people who can live independently at home but need small amounts of support to do so.

The CHSP is not designed for people with intensive or complex care needs. People with higher needs are supported through other aged care programs such as the Support at Home program or residential aged care.

CHSP service catalogue 2025-2027

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

6.5.1. Care Finder program and Elder Care Support program participants

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

Elder Care Support program

Care Finders program

6.5.2. Access to CHSP services

From 1 November 2025 anyone seeking CHSP services will require an aged care needs assessment. This means providers must ensure:

- All clients are recorded in My Aged Care with a My Aged Care ID, **and**
- Clients have a care plan recorded in My Aged Care, which describes the client's assessed care need.

6.5.3. Assessing for and recommending CHSP

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

- In some circumstances, existing CHSP clients may need to contact My Aged Care and be referred for an assessment or reassessment to continue receiving services. This includes:
    - A client's needs can change, such as a need for a new service type or a significant increase to support needs. As part of their re-assessment, the client may be assessed as eligible for continuing care through CHSP or may be assessed as eligible for Support at Home.
    - There are some existing CHSP clients who have never been assessed. This includes clients who have been 'grandfathered' into the CHSP from previous programs. From 1 November, it is a requirement for all of these clients to be referred for an assessment, even if they are already accessing CHSP services.

Note: From 1 November, a key process change is that assessors should not issue CHSP referral codes until *after* the assessment delegate has approved the recommendation. This is because all CHSP services will require assessment delegate approval as of 1 November 2025.

6.5.4. Hoarding & squalor assistance

Hoarding and squalor assistance aims to support older people or prematurely aged people who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need.

Eligibility

Frail older or prematurely aged people who meet the following 3 criteria:

1. on a low income
2. living with hoarding behaviour and/or in a squalid living environment
3. at risk of homelessness or unable to receive the aged care services they need.

Prematurely aged people are those aged 50 years and over whose life course such as active military service, homelessness or substance abuse, has seen them age prematurely.

Note:

From 1 November 2025, new clients that are Aboriginal and Torres Strait Islander people who are 45-49 years old are no longer eligible to access Hoarding and Squalor assistance.

Older people who are eligible to access hoarding and squalor assistance, remain eligible for this service indefinitely and do not require a reassessment for hoarding and squalor assistance, even if they suspend services for several years. These older people are also eligible to access other CHSP services targeted at avoiding or reducing the impact of hoarding and squalor situations.

Assessment organisations are required to work collaboratively with hoarding and squalor assistance service providers in supporting older people to access aged care due to their particular circumstances. Hoarding and squalor assistance service providers link older people to the most appropriate range of housing and care services in order to meet their immediate and ongoing needs. The range of hoarding and squalor services may include:

- one-off clean-ups

- developing a client plan and reviewing care plans
- linking to specialist support services.

It is recognised that a specialised approach is required for hoarding and squalor assistance clients due to their particular circumstances.

It is appropriate for aged care assessors to refer suitable clients identified during the assessment process to the hoarding and squalor assistance or care finders for further support.

Where there are significant changes in need or additional services needed, CHSP providers can request a Support Plan Review, which may lead to a reassessment.

Out-of-scope activities under this service type

- Assessment (referrals) and advocacy services (financial, legal), unless targeted at avoiding or reducing the impact of hoarding and squalor situations.
- Permanent support and/or direct care provision.
- Funding to purchase accommodation for clients.
- Hoarding and squalor clients are exempt from paying a client contribution towards their services.

6.5.5. Understanding AT and HM under CHSP

AT and HM services will continue to be available to eligible people under the CHSP. The relevant service types from the CHSP service catalogue are:

- Home adjustments: subsidised home modification services up to $15,000 per year.
- Equipment and products: subsidised low-cost assistive technology and products up to $1,000 per year.

To access these services eligible people will be approved for:

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

Note:
There are not multiple funding tiers for AT CHSP and HM CHSP as there are under the Support at Home AT-HM scheme.

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

CHSP service list for Equipment and products and Home adjustments from 1 November 2025:

Equipment and products

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

Home adjustments

- Home modifications

6.5.6. Interactions between CHSP and other programs

There are limited circumstances where a person can access CHSP services in addition to other government funded services, detailed in tables 28 and 29 below.

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

Table 28. Guide to approval for concurrent access to CHSP services with other government funded services

Program	Can participant access CHSP services?
Support at Home participants (including Restorative Care Pathway and End-of-Life Pathway)	There are four circumstances where a Support at Home participant can access additional services through the CHSP. These are: 1. Pre-existing CHSP social support group 2. Hoarding and Squalor 3. Cottage respite, Community and centre-based respite and Flexible respite 4. Emergency Access (see table 28 below for further detail).
Waiting for a Support at Home place allocation	The participant can access interim CHSP services. Interim CHSP services are also available for a participant who has been assessed as needing a higher Support at Home classification but are waiting for their increased budget. If a Support at Home participant declines to take up the classification, they can continue to access entry level CHSP services as a CHSP client. They will not access CHSP services to the level of the Support at Home classification they were approved for.

Program	Can participant access CHSP services?
Existing Home Care Package recipients accessing 'top up' CHSP services	Where the HCP recipient is accessing additional CHSP services in addition to their HCP, from 1 November they would transition to a Support at Home classification. The CHSP services would cease as they will be supported through the Support at Home program. If they need additional services through the CHSP, these would be on a full cost recovery basis, unless the limited circumstances listed in table 29 apply.
Residential Aged Care and Residential Respite Care	Individuals in Residential Aged Care cannot access Government-funded CHSP services. They may choose to access services on a full cost recovery basis.
Disability Support for Older Australians, National Disability Insurance Scheme (NDIS), NATSIFAC Program, Transitional Care Program (TCP) and Veterans' Home Care Program	Can access CHSP services, as long as they have a referral and there is no duplication of services.

There are **limited** circumstances where a Support at Home participant can access CHSP services:

Table 29. Circumstances when a Support at Home participant can access CHSP services

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

6.5.7. Other CHSP services can be accessed at full cost recovery

Support at Home participants can choose to pay for additional CHSP services out of their quarterly Support at Home budget.

The participant must pay for the entire cost of services (known as full cost recovery). For example, if the Support at Home participant received meals from the CHSP, they would be charged the full cost of the meals, including ingredients, preparation and distribution costs.

The participant is only able to access CHSP services that are also on the Support at Home service list and included in their support plan.

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

If the IAT Outcome is CHSP **only**, a Notice of Decision will **not** be automatically generated. Assessors will need to use an offline template for the Notice of Decision letter.

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

At the moment, Assessment Delegates are not able to record their agreement or disagreement alongside each CHSP service recommendation in the assessor portal. Their decision to agree with the recommended CHSP services must be recorded in the Notice of Decision. If approving the client for the CHSP classification only (that is, the Assessment Delegate is not approving any ongoing or short-term Support at Home classification), the My Aged Care Assessor Portal will not currently generate the *approval* version of the Notice of Decision. In this situation, you will need to use the offline Notice of Decision (approval) template.

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

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

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

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

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

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

See 6.5.6 section for further details about when an individual with a SaH classification can be approved to access CHSP services.

6.5.10. Time-limited definition

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

6.5.11. Wellness and reablement under CHSP

Reablement approaches under CHSP involve recommending time-limited services for a period of up to 12 weeks. Time-limited support aims to address a specific barrier to independence and to support the older person getting back to doing things for themselves. This involves a targeted timeframe, developed with the older person, to achieve their goals.

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

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

Department of Health, Disability and Ageing website:

- Commonwealth Home Support Program (CHSP) 2025-27 Manual | Australian Government Department of Health, Disability and Ageing
- Wellness and reablement resources
- Living Well at Home – CHSP Good Practice Guide

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

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

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

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

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

6.6.1. Assessing for NATSIFACP

From 1 November 2025 anyone seeking NATSIFACP aged care services will require an aged care needs assessment under the *Aged Care Act 2024*. NATSIFACP providers can also make this application on the older person's behalf, either by phone or online. This may include supporting the older person by self-referring the assessment to known assessment organisations in the area, including Aboriginal and Torres Strait Islander assessment organisations in future.

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

contributions are also variable and take into account the capacity of individuals to contribute toward the cost of the services delivered to them.

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

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

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

6.6.2. Recommending NATSIFACP pathway

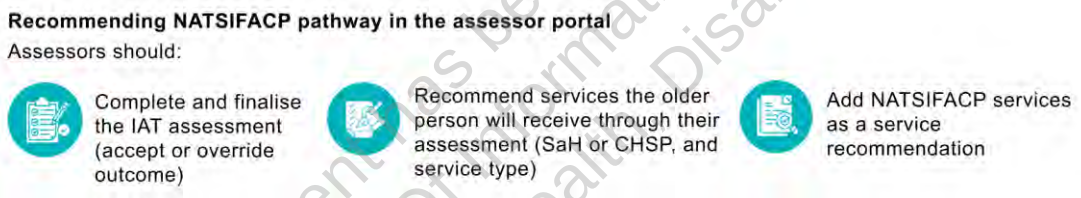

Figure 5 – recommending NATSIFACP pathway in the assessor portal

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

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

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

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

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

6.6.3. Interactions with other programs

All service groups and types can be delivered under NATSIFACP.

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

For further information, please refer to the NATSIFACP Manual.

6.7. Multi-Purpose Service Program (MPSP)

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

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

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

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

6.7.1. Assessing for MPSP

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

6.7.2. Recommending MPSP pathway in the assessor portal

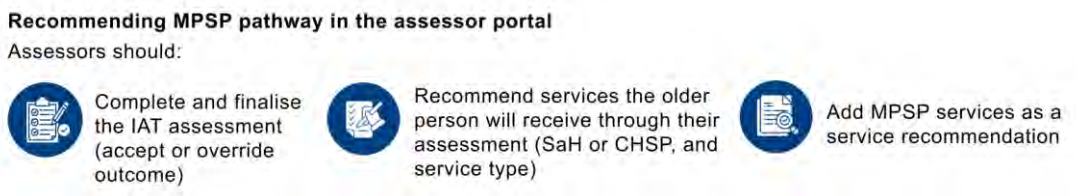

Figure 6 – Recommending MPSP pathway in the assessor portal

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

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

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

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

6.7.3. Interactions with other programs

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

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

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

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

6.7.4. Referrals to NATSIFACP and MPSP providers

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

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

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

Assessment Delegates are responsible for approving service recommendations.

Important:

It is not sufficient to only make a service recommendation for MPSP or NATSIFACP, as an individual cannot access services under these programs without an access approval from a delegate for one or more service groups.

If the client has been approved for home support with an ongoing Support at Home (SaH) classification or for the AT-HM scheme, but intends to initially access services through their local MPSP or NATSIFACP provider, the assessor should set the 'Seeking Services' field to 'No' for one or all of these recommendations as needed. This must be confirmed with the individual before selecting the field. This will prevent the individual from being added to the prioritisation queue(s) for these services and being offered a place which they do not intend to accept at that time. You should not do this if you expect the older person will need to concurrently access services from both the MPSP/NATSIFACP and SaH program and/or the AT-HM scheme.

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

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

6.8. Transition Care Program (TCP)

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

Services include:

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

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

6.8.1. Access to transition care

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

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

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

- medically stable at the time of assessment; and
- is in the concluding stage of a hospital episode; and
- has the potential to benefit from accessing services delivered through the relevant service group under the TCP; and
- at the time the assessment was carried out, an admitted hospital patient. This includes people receiving hospital-in-the-home. It excludes people in Emergency Wards.

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

6.8.2. Recommending transition care

When recommending Transition Care, an assessor will need to override the IAT outcome to 'ineligible for CHSP/SaH' and then choose the 'Transition Care' option under the 'Add a Care type for Delegate Decision' button. Transition Care will then continue to be recommended and approved as per the existing process. The system will still allow CHSP services to be recommended concurrently with TCP if required.

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

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

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

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

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

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

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

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

When the older person is approved as eligible for transition care at the time of the initial assessment, it is likely they will need a re-assessment before the completion of their transition care episode, to establish their long-term care requirements. Where this is necessary, the assessor should review any changes to the person's care needs and ensure that the long-term care recommendations reflect the revised level of need and the person's preferences. In very limited circumstances, the clinical assessor may determine that the older person requires an approval for both ongoing Support at Home and TCP, which may be accessed concurrently'

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

Support at Home and CHSP participants can access TCP after a hospital stay if they are assessed and approved as eligible by an aged care assessor. Support at Home and CHSP

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

6.8.4. Accessing residential care/residential respite and transition care

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

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

6.8.5. Duration of transition care

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

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

Lapsing of transition care approval

A transition care approval will lapse under the following circumstances:

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

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

Breaks in care

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

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

6.8.6. Transition care extensions

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

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

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

When recording a decision to approve an individual for Transition Care, a drop-down box will require the assessor to select a priority. From 1 November 2025, there is no priority system in place to receive services through Transition Care and the priority value will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority to 'high' for all assessments.

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

6.9. Residential care

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

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

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

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

Application and approval for residential care means the person meets the eligibility criteria and the care type is appropriate for their care needs. To be approved for residential care a delegate must be satisfied that section 68 of the Act applies to an older person who is not Aboriginal and/or Torres Strait Islander. The older person must be 'sick' and because of that 'sickness' have a continuing need for residential care. For further information on the Act's definition of sickness and approvals under section 68, refer to section 7.6.4 of Chapter 7.

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

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

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

1. meals (including special diets)
2. bathing, showering, dressing and personal hygiene
3. toileting and continence management
4. general nursing care (e.g. wound management)
5. organising and taking medication
6. communication (including fitting sensory or communication aids)
7. transfers and mobility
8. assessment and referral for appropriate support; and/or
9. emotional support

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

An assessor will need to consider the person's:

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

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

6.9.1. Recommending residential care

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

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

6.9.2. Priority for ongoing residential care

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

Table 30. Description of priority categories

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

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

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

6.9.3. Urgency rating for residential care

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

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

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

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

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

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

Relevant factors to consider in determining urgency may include:

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

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

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

Table 31. Guide to urgency ratings for residential care

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

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

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

Clients residing in rural and remote areas

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

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

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

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

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

6.9.4. Place allocation

From 1 November 2025, the new residential care system will allocate residential care places (permanent or respite) directly to older people. This is the ‘Places to People’ reform.

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

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

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

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

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

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

6.10. Residential respite care

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

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

6.10.1. Recommending residential respite care

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

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

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

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

Note:

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

6.10.2. Extensions for residential respite

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

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

The Assessment Delegates' responsibility is to review the request and either approve or decline it. Once a decision is made, they must communicate the outcome to the provider.

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

(a) carer stress

(b) severity of the individual's condition

(c) absence of the individual's carer

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

Note:

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

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

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

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

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

6.11. Other programs and supports

6.11.1. Dementia specific programs and supports

Counselling, education, information, and other support for people living with dementia or experiencing cognitive decline, and their care partners, families, and representatives is available by contacting the National Dementia Helpline on **1800 100 500** or visiting the Dementia Australia website.

The National Dementia Helpline is available 24 hours a day, 7 days a week. Dementia Australia is the sole provider of National Dementia Support Program services.

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

Note:
An older person does not need a cognitive diagnosis to be referred to Dementia Australia for support.

6.11.2. Dementia Carer Respite and Wellbeing Program

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

The program expands on existing supports to:

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

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

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

6.11.3. Dementia behaviour supports

Dementia Behaviour Management Advisory Service (DBMAS), delivered by Dementia Support Australia (DSA), provides free support and advice to service providers and individuals caring for people with dementia in any location or setting in Australia. It provides support when the behavioural and psychological symptoms of dementia (BPSD) start to impact a person's quality of care. Family carers and service providers can contact the 24-hour DSA helpline for advice on **1800 699 799**.

Severe Behaviour Response Teams (SBRT), also delivered by DSA, is a mobile service that responds onsite within 48 hours. It offers free support and advice to approved aged care providers where there is heightened severity of BPSD or risk to the person living with dementia, or their care network. SBRT will partner with the person living with dementia and their care network to understand the causes that led to changes in behaviour. Providers can contact the 24-hour DSA helpline for advice on **1800 699 799**.

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

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

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

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

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

6.11.4. Specialist dementia care

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

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

Referral and eligibility for the program is undertaken by Dementia Support Australia (DSA) through the Needs Based Assessment Program. DSA can be contacted on **1800 699 799**.

Dementia Support Australia

Staying at Home

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

Specialist Dementia Care Program information booklet

6.11.5. Department of Veterans' Affairs (DVA)

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

Veterans' Home Care (VHC) Program

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

Community nursing (CN)

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

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

Duplication of services

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

- Ongoing Support at Home
- CHSP
- TCP

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

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

Assistance with fees

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

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

6.11.6. NDIS participants

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

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

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

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

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

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

The following services under CHSP will not affect DSOA funding:

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

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

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

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

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

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

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

Department of Health, Disability and Ageing website:

Disability Support for Older Australians Program (DSOA) manual

About the Disability Support for Older Australians Program

6.11.8. Carer support

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

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

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

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

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

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

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

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

Assessors should collect carer information in the My Aged Care Assessor Portal or Aged Care Assessor App and register the older person and their carer's consent to request a call back from Carer Gateway and/or the National Dementia Helpline. The carer's local CGSP

and/or the National Dementia Helpline will then contact them to assist with accessing supports to help them in their caring role.

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

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

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

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

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

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

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

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

Carer Gateway website

Carer Gateway service provider free call:1800 422 737

Department of Health, Disability and Ageing website:

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

Young Carers Network website

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

6.11.9. Aged Care Volunteers Visitors Scheme (ACVVS)

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

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

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

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

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

6.11.10. Translating and Interpreting Service (TIS) National for people from culturally and linguistically diverse backgrounds

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

If an older person requires an interpreter, TIS National's interpreting services are available 24 hours a day, 7 days a week, and can be accessed via telephone or through face-to-face sessions.

TIS National offers interpreting services for more than 70 years and has access to more than 2,700 interpreters, in over 150 languages and dialects, across Australia.

To access TIS National interpreting services, you first need to register by calling 1300 655 820 or emailing tispromo@homeaffairs.gov.au. Speak to your team manager, who will be able to provide advice about how you can book an interpreter.

Sign language interpreting services

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

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

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

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

6.11.11. Interpreting services for Aboriginal and Torres Strait Islander people

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

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

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

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

6.11.12. Elder Care Support

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

The Elder Care Support program provides services that include:

- supporting older Aboriginal and Torres Strait Islander people to understand aged care services, navigate the assessment process and help with choosing a provider
- supporting families, friends and carers to understand how to access aged care services
- advocating for older Aboriginal and Torres Strait Islander people by working with assessors and providers to meet their needs

- supporting older Aboriginal and Torres Strait Islander people while they receive aged care services
- assisting with other types of health needs, such as disability supports.

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

Elder Care Support

6.11.13. Care Finders

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

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

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

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

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

Care finder program

7. Chapter 7: Delegations and approvals under the Act

What you'll find in this chapter

This chapter includes information about:

- the powers under the *Aged Care Act 2024* that are delegated to Triage Delegates and Clinical and Non-Clinical Assessment Delegates.
- how approvals work under the *Aged Care Act* 2024, and the decisions that delegates make.

All sections in this chapter are new content

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

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

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

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

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

7.2. Delegate responsibility

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

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

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

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

There are three delegate positions which sit within assessment organisations:

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

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

Table 32. Assessment related activities of delegate positions

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

Delegate position	Delegate activity
	• Consider and determine the outcome of a classification reassessment

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

7.3. Triage Delegates

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

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

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

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

7.4. Assessment Delegates

7.4.1. Non-clinical Assessment Delegates

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

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

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

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

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

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

7.4.2. Clinical Assessment Delegates

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

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

7.5. Overview of approvals under the Aged Care Act 2024

The *Act* brings a major shift in how individuals are approved to access funded aged care services.

Before the *Act*, approvals for funded aged care services were largely program focused. Some approvals were given under the *Aged Care Act 1997*, and some were not.

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

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

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

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

1. **Service groups,** which specify the setting and nature of care an individual can access
2. **Classification types,** which specify the different time periods that services are delivered for under the service group.
3. **Service types** and **services** (for some older people, in some circumstances) – Service types are groups of different services. The services under these types are set out under the Aged Care Service list. Different service types sit under each

service group. Older Aboriginal and Torres Strait Islander people only need an approval at the service group level – they are automatically approved for all service types and services in that group.

4. **Classification levels,** which determine the amount of funding available to deliver funded aged care services to the individual. The individual receives a classification level for the classification type for the service group they have been approved to access. The classification levels are specified in the Rules (see Division 3 Part 3 of Chapter 2 of the Rules).
5. **Priority categories** – determines priority for a classification type for a service group.

An assessment delegate will make approval decisions for all of these elements, with the exception of priority categories, which may be made by or with the assistance of an algorithm.

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

7.6. Delegate decisions under the Aged Care Act 2024

Although assessors provide recommendations and supporting evidence via the assessment report (support plan), the final approval decision rests solely with the Assessment Delegate.

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

Once an aged care needs assessment is finalised, the Assessment Delegate must ensure that all eligibility requirements are met before approving any service group, service type, or specific funded aged care service. This means that the older person's situation must comply with the conditions outlined in sections 65-68 of the Act and any additional eligibility criteria set by the relevant rules must be satisfied. If these requirements are not met, the Assessment Delegate cannot approve the provision of aged care services.

7.6.1. Deciding if the older person requires aged care services

Assessment Delegates must first determine whether the individual requires access to funded aged care services, and which service groups, and in some cases service types and services they require. This requirement is set out in section 65(2) of the *Aged Care Act 2024* (the Act).

This decision is made based on:

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

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

Table 33: Approval to access funded aged care services under section 65

Section of the Act	Section 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.
67	Individual must have an impairment; **and** There must be a specific reason why the individual requires access to the service type/s or services. The individual must meet any eligibility requirements prescribed by the rules for the relevant service group.	• Home Support • Assistive Technology • Home modifications	All classification types	• Support at Home • CHSP • TCP • MPSP • NATSIFACP
68	Individual must have a continuing need for residential care because they are 'sick' The individual must meet the eligibility requirements prescribed by the rules for the service group residential care.	• Residential Care	All classification types	• Residential care (ongoing or short-term) • TCP • MPSP • NATSIFACP

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

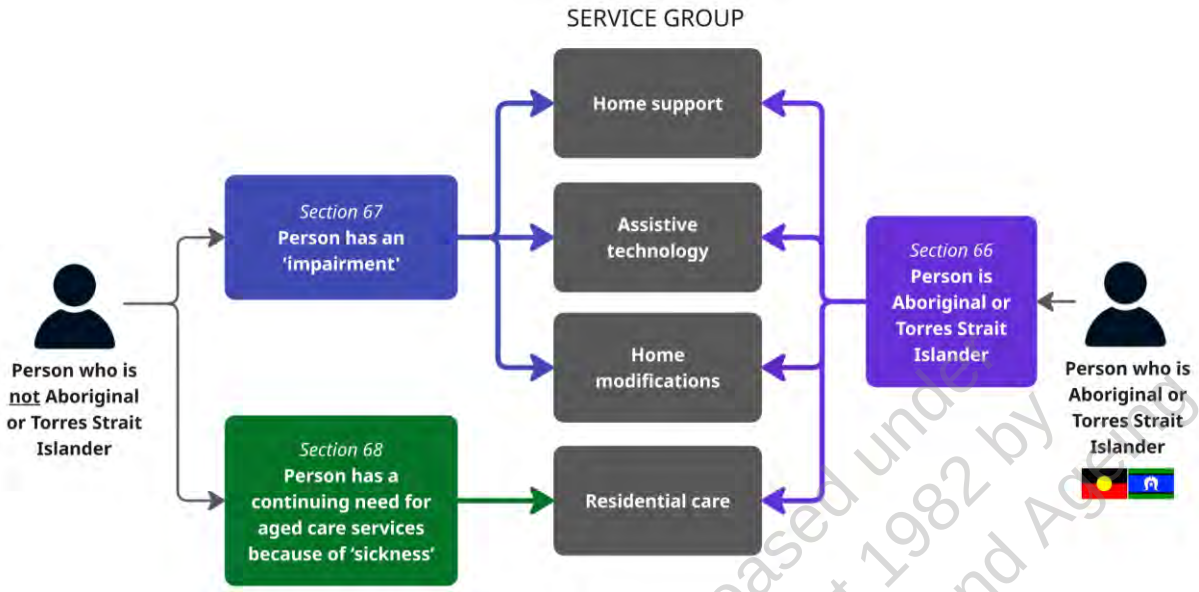

Figure 7 – Overview of pathways to approval for service access under the Act

7.6.2. Section 66 – Aboriginal or Torres Strait Islander persons

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

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

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

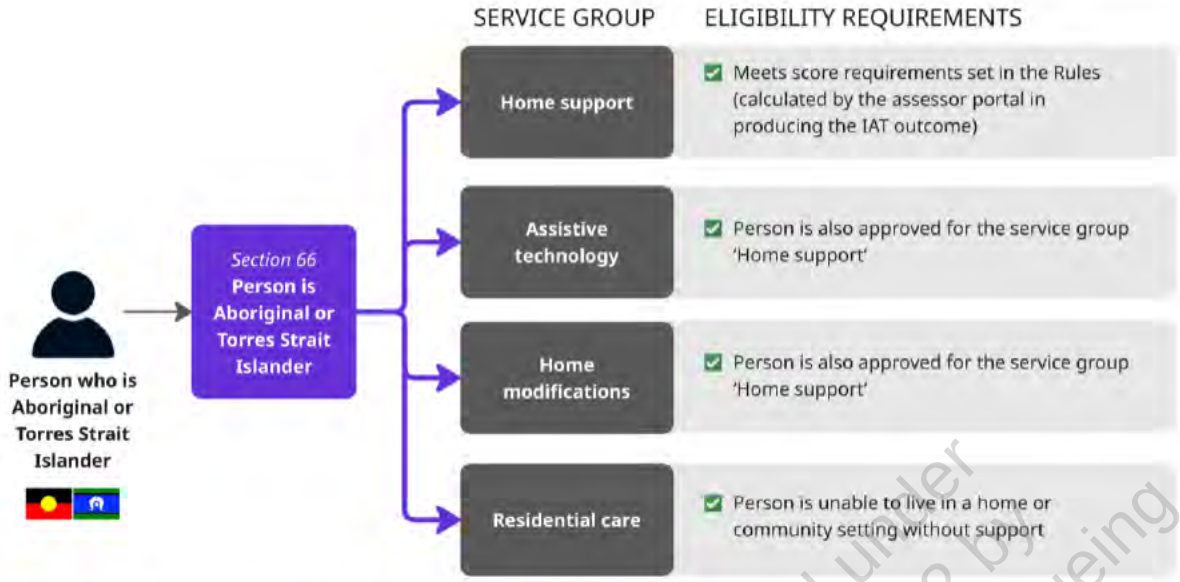

Figure 8 – Overview of section 66 pathway to approval for service access

Additional eligibility requirements

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

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

Additional eligibility requirements for home support

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

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

Table 34. Additional eligibility requirements for the home support service group under section 66

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

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

Additional eligibility requirements for assistive technology and home modifications

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

Additional eligibility requirements for residential care

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

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

Section 67 is the pathway for older people (who are not Aboriginal or Torres Strait Islander) to be approved under section 65(1) for the following service groups:

- home support
- assistive technology
- home modifications.

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

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

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

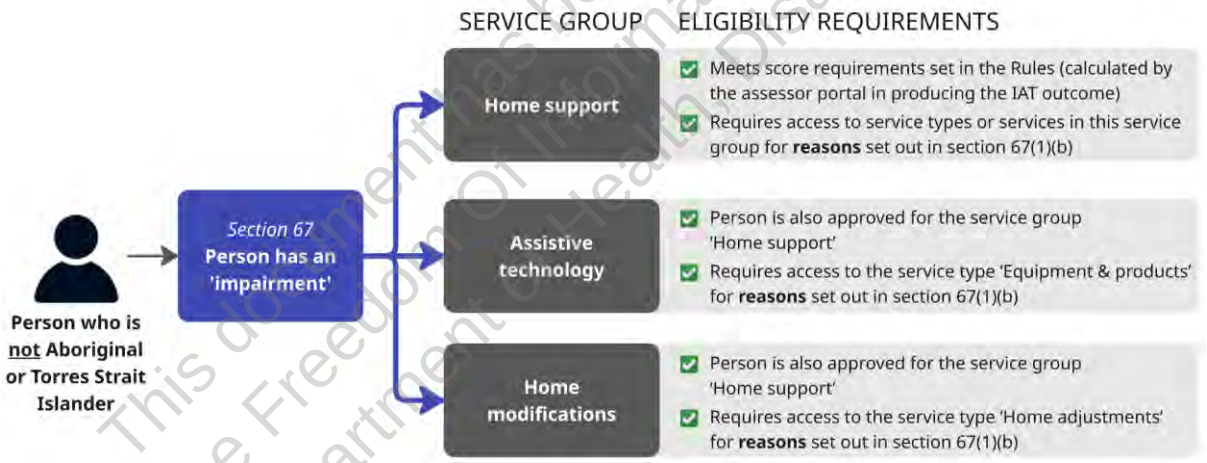

Figure 9 – Overview of section 67 pathway to approval for service access

Deciding if the person should be approved

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

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

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

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

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

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

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

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

Impairment

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

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

EXAMPLE 1

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

EXAMPLE 2

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

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

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

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

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

Specific reason/s why access is needed under Section 67

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

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

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

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

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

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

v. is a habilitation or rehabilitation service

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

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

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

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

Table 35. Reframed reasons for access under section 67

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

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

Service types/services and potential applicable reasons are set out in the table on the following page.

Table 36. Service types/services and potential applicable reasons under section 67

Reason	Home Support	Assistive Technology (Only has one service type)	Home Modifications (Only has one service type)
1. Requires support to live and be included in the community and prevent from being isolated or segregated from their community	All service types except Nursing	Equipment & Products	Home Adjustments
2. Requires support with personal mobility or requires a mobility aid/device/assistive technology	Transport	Equipment & Products	Home Adjustments

Reason	Home Support	Assistive Technology (Only has one service type)	Home Modifications (Only has one service type)
3. Would benefit from services to minimise the prospects of them, or prevent them from, acquiring a further impairment	Assistance with transition care	Equipment & Products	Home Adjustments
4. Needs support to access any of the services they have been approved for	• Assistance with transition care • Restorative care management	Equipment & Products	
5. Requires health services because of their impairment or because of the impairment and its interaction with various barriers	• Allied health and therapy services[4] • Nursing care • Therapeutic services for independent living[5]		
6. Requires support with rehabilitation or to gain a new skill or function (habilitation)	Assistance with transition care		

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

Health services - examples

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

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

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

Habilitation and rehabilitation services - examples

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

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

Additional eligibility requirements

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

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

Additional requirements for home support

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

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

Table 37. Additional eligibility requirements for the home support service group under the Rules

A person has a total score of less than 20 for the questions in the IAT with the following headings:	• Climb stairs • Eating • Dressing • Take a bath or shower • Grooming • Transfers • Toilet use • Toileting – bladder • Toileting – bowels • Walk
OR	
The person has a total score of less than 14 for the questions in the IAT with the following headings:	• Get to places out of walking distance • Undertake housework (heavy/moderate) • Go shopping (assuming transportation) • Prepare meals

The person has a score greater than zero for the questions in the sections of the IAT headed:	• Take medicine • Handle money • Use the telephone
OR	
	• Cognition • Medical and Medications
OR	
The individual has a score greater than zero for questions in the section of the IAT headed:	• Psychological
OR	
The individual has a score greater than zero for the questions in the section of the IAT headed:	• Physical, Personal Health or Frailty

Additional requirements for assistive technology and home modifications:

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

7.6.4. Section 68 – 'individuals with a sickness'

Section 68 is the pathway for older people (who are not Aboriginal or Torres Strait Islander) to be approved under section 65(1) for funded aged care services in residential care.

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

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

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

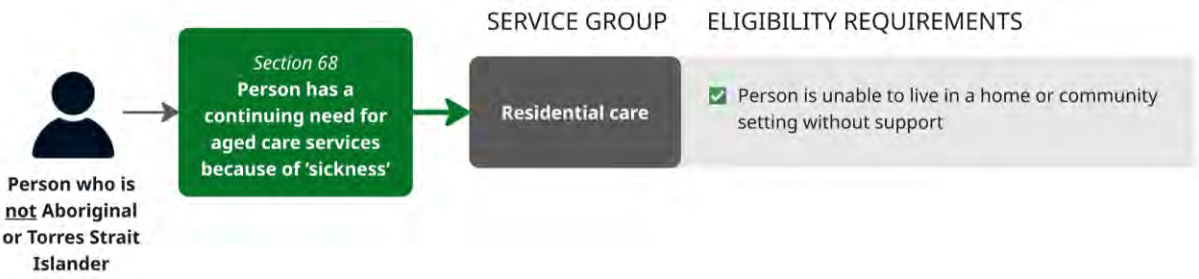

Figure 10– Overview of section 68 pathway to access approval for residential care

Deciding if the person should be approved

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

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

Sickness

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

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

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

Additional eligibility requirements

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

The additional requirement is:

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

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

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

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

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

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

Table 38. Comparison of approvals under the Aged Care Act 1997 and Act Care Act 2024

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

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

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

7.7.1. Service group: Home support

Table 39. Possible combinations of classification type and classification level under the service group of home support

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

7.7.2. Service group: Assistive technology

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

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

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

7.7.3. Service group: Home modifications

Table 41. Possible combinations of classification type and classification level under the service group of home modifications

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

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

7.7.4. Service group: Residential care

Table 42. Possible combinations of classification type and classification level under the service group of residential care

Service group	Classification type	Classification level
Residential Care	**Ongoing**	Class 0 Class 1 to Class 13
	Short-term	Class 0 Respite class 1 to Respite class 3
	Hospital transition	RC HT class

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

7.8. Approvals for service types and services

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

Important:

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.

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

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

Note:

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

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

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

7.9. Approvals for priority categories

Priority categories are assigned to individuals (under section 86 of the Aged Care Act 2024 (the Act)) to determine when certain services are allocated under section 92 of the Act. These categories are based on the assessed urgency of need, complexity of care requirements and potential risks associated with delayed support.

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

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

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

In practice, this looks like the following:

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

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

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

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

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

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

7.9.1. Home support – ongoing

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

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

7.9.2. AT-HM scheme

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

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

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

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

7.9.3. Residential care

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

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

7.10. Period of effect of approvals

Each access approval, classification level, and priority category has a period of effect that is prescribed under the Aged Care Act 2024 (the Act),. This means that access approvals remain in effect for the period of time specified by the Act, unless the approval is revoked or a reassessment occurs resulting in a new approval.

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

- An access approval that is in effect (or 'active') and

- A classification level that is in effect

Periods of effect for an approval decision made by Assessment Delegates are detailed in sections 71, 80 and 89 of the Act.

7.10.1. Period of effect of access approvals

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

In some situations, the date of the access approval specified in an individual's notice of decision can be set earlier than the date the approval was actually given, referred to as 'alternative entry' (prescribed in section 71 of the Act). This flexibility exists to accommodate situations where the individual required urgent care or access to getting an appropriate assessment was limited.

7.10.2. Period of effect of classification levels

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

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

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

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

7.10.3. Period of effect of priority categories

When the priority category for a classification type for a service group is decided, this determines the level of priority for accessing those services.

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

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

7.11. Reassessment of a classification level

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

Table 44. Circumstances when a classification reassessment can be sought

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

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

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

If the application meets the necessary criteria, a reassessment will be carried out, and a new recommendation will be prepared and presented to the Assessment Delegate. Assessment Delegates are responsible for deciding whether to approve a different classification level for the classification type for a service group or an extension of the classification level (if

relevant) under section 78 of the Aged Care Act 2024 (the Act),. All new decisions must be documented in a new Notice of Decision letter which must be made in accordance with the requirements of section 79 of the Act.

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

7.12. Summary of Assessment Delegate responsibilities under the Act

The table below summarises all of the decisions that Assessment Delegates are empowered to make or actions they are empowered to take under the Aged Care Act 2024 (the Act),. Assessment Delegate responsibilities include notifying the older person (and their registered supporter/s, if applicable) of the outcome of their assessment; this is explained in detail in the following chapter.

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

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

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

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

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

8. Chapter 8: Delegate decisions in practice

What you'll find in this chapter

This chapter includes guidance for Assessment Delegates covering:

- how to make sound, evidence-based decisions
- step-by-step processes for approving aged care services across the service groups
- other approvals (including giving approvals after a service has commenced and approving a service without an assessment).

All sections in this chapter are new content

8.1. Decision-making fundamentals

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

8.1.1. Essentials of good decision-making

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

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

- **Identify all material facts:** Delegates must establish all material facts that are essential to the decision. Only facts supported by reliable evidence should be taken into account.
- **Base decisions on evidence:** Avoid making decisions based on unsubstantiated facts. Every finding must be backed by relevant and logical evidence that clearly supports the conclusions.
- **Ensure reasonable judgement:** Delegate decisions must be reasonable and not be based on findings that are manifestly unreasonable. This means that the conclusions should be rational, defensible, and clearly justifiable.
- **Observe natural justice:** Delegates must respect the principles of natural justice throughout the decision-making process. In essence, this means ensuring that individuals are given a fair opportunity to explain their circumstances before a decision is made.

- **Comply with legal requirements:** Delegates must comply with any statutory obligations, including understanding the important new eligibility criteria for approvals and the requirement to provide a written statement of reasons when necessary.

8.1.2. Best practice guides for decision-making

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

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

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

Note:

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

8.2. Quality assurance

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

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

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

8.2.1. Validating the assessment process and evidence

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

- Validate the assessment process
- Review the assessment evidence

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

8.2.2. Validating the assessment process

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

In line with the Act, Assessment Delegates must confirm the assessment:

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

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

Note:

Supporting independence, autonomy, empowerment and freedom of choice.

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

8.2.3. Review the assessment evidence

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

Assessment Delegates must carefully examine the documentation to confirm:

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

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

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

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

8.2.4. Assessment information and evidence

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

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

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

Support plans

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

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

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

It is essential that the assessment summary is written clearly and succinctly, following the ISBAR format−Introduction, Situation, Background, Assessment, and Recommendation see section 5.9.1 in Chapter 5.

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

The support plan must be consistent with the information collected using the IAT and any other relevant information gathered during the assessment, such as GP health summaries. The assessment summary should clearly inform the goals, recommendations, and any areas of concern outlined in the support plan. These elements should reflect what the person is concerned about, what they hope to achieve or change, and how funded aged care services can support them in addressing their needs and aspirations.

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

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

- **Why is the person having a needs assessment?** - The support plan should clearly articulate the purpose of the assessment. Look for background information that explains the circumstances leading to the referral and the rationale for undertaking the assessment.
- **What are the older person's identified needs?** - Confirm that the support plan provides a comprehensive and evidence-based description of the older person's needs. This should encompass physical, medical, psychological and social domains as identified through the IAT and other validated assessment tools.
- **What types of support are required, and why?** - Ensure the support plan outlines the specific supports recommended along with a clear justification for each. These

should be directly linked to the older person's assessed needs and supported by relevant evidence.

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

Once finalised, the support plan is sent to the older person, and their registered supporter/s and/or appointed decision makers as applicable, as a record of the assessment, accompanied by a Notice of Decision letter. Registered providers also use the support plan to inform the individual's care plan, therefore accuracy and clarity essential.

Referral information

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

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

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

Record of consent

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

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

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

Application for Care form

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

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

Triage Delegates must review the form for completeness and be satisfied that the requirements under s58 are met. The Assessment Delegate is responsible for reviewing and approving the application form.

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

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

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

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

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

Additional evidence

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

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

Note:

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

8.3. Approving home support

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

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

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

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

8.3.2. Step 2. Decide the classification type and level

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

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

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

Chapter 5 provides guidance to assessors to accept the IAT Outcome if they are intending to recommend ongoing home support services through CHSP or Support at Home. Before approving any recommended classification level, assessment delegates must ensure that

the classification level recommended by the assessor is the same as the classification level generated by the IAT Outcome. The system-generated recommendation is labelled 'IAT outcome', and the assessor's recommendation is labelled 'Recommended classification'. If these two values are different, then the assessor has overridden the IAT outcome.

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

Note:

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

-SaH Restorative Care Pathway,

-SaH End of Life Pathway,

-Transition Care Program,

-Permanent Residential Care without ongoing in-home services,

-Residential Respite care without ongoing in-home services.

Approving CHSP services alongside Support at Home classifications

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

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

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

Approving the SaH Restorative Care Pathway

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

For SaH participants receiving ongoing services at the time the RCP is approved, the RCP episode can be accessed concurrently with their ongoing services. This allows individuals to continue using their ongoing services while also receiving additional, clinically focused services through RCP.

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

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

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

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

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

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

Note:

The IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs. Where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.) An ongoing SaH classification must be generated by the IAT to override and recommend RCP for approval.

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

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

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

If the individual is reassessed and recommended for an ongoing SaH classification while undertaking the RCP, the restorative care episode will end immediately upon delegate approval of the ongoing SaH classification.

Approving restorative care - guidance for Assessment Delegates

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

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

The Assessment Delegate is also responsible for making sure all decisions follow pathway rules, including:

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

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

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

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

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

Eligibility considerations and exclusions

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

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

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

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

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

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

Manual oversight of restorative care places

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

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

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

they will also be accessing the RCP units of funding for the first six months from 1 November 2025.

A second unit of funding to use within a single RCP episode can be requested via a Support Plan Review (SPR) request noting the assessor will need to .

self-refer this for reassessment to grant access to a second unit of funding (see Chapter 6).

The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request. Availability of the RCP funding units may also be considered. When a request for a second unit of RCP received assessors should confirm if there is approval for STRC and RCP on the client's record. If there is approval for both, the assessor will need to confirm with the client if they entered care under the RCP after 1 November 2025 using the STRC approval. If this is the case, then the assessor must not approve a third unit of RCP funding.

If the participant is eligible to access an additional restorative care pathway they must wait at least 12 months before accessing another episode.

Assessment Delegates will need to remain acutely aware of any communication from the department regarding RCP caps to ensure they are making informed decisions. These

communications will be the **primary tool** for identifying when RCP units are nearing exhaustion. Being responsive to these insights is essential for maintaining compliance with pathway limits and avoiding over-allocation.

Restorative care funding

The Restorative Care Pathway (RCP) provides around $6,000 of funding (one unit), for up to 16 weeks. The total amount of funding a participant uses and length of time to complete an episode can differ. Restorative care partners will consider this when developing the goal plan.

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode. If the participant requires additional funding within a single 16-week episode, the provider can submit a request for a Support Plan Review. If certain circumstances are met, approval can be given for the additional $6,000 in funds to support the episode.

If approved, a participant can access an additional unit of funding (up to $6,000), to provide a combined total of up to $12,000 (two units), for a single episode of restorative care. If additional funding is approved, a participant will not be eligible for a further episode of restorative care within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

Important:

- The decision to approve additional concurrent funding to the RCP episode is made under subsection 195-3 of the *Aged Care Rules 2025 (the Rules)*. It is a non-reviewable decision. The criteria in the Rules includes that required evidence must be given by the participant's provider and there must be units of funding available for approval.
- The assessment delegate must send a letter to the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) notifying them of the outcome of the application for the additional funding.

Approving the End-of-Life Pathway

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

End-of-Life Pathway form

The End-of-Life Pathway form is used to document the required medical evidence for accessing the End-of-Life Pathway under the Support at Home program. An individual seeking access to the End-of-Life Pathway must complete all relevant sections and present this form to a medical practitioner or nurse practitioner for completion. The completed form should then be submitted as part of the assessment process—either before or during triage, or assessment—and reviewed to confirm eligibility for the End-of-Life Pathway.

The Assessment Delegate is responsible for verifying the completion of this form in the older person's record when the End-of-Life Pathway has been flagged in the My Aged Care assessor portal.

Reviewing the form will involve:

- Checking the individual's details to ensure they match the record in the portal.
- Verifying the completion of all areas of the Medical Assessment section to confirm
    - The individual has a prognosis of a life expectancy of three months or less, and
    - An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
    - Medical practitioner or nurse practitioner has completed and signed the form.

An individual will **not** be eligible for approval for the End-of-Life Pathway if the required criteria outlined in the medical assessment section are not met.

8.3.3. Step 3. Decide the service types and services

Older person is Aboriginal and Torres Strait Islander

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

Older person is neither Aboriginal nor Torres Strait Islander

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

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

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

Check to make sure the required services are selected

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

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

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

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

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

Note:

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

Review CHSP service recommendations

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

At the moment, Assessment Delegates are not able to record their agreement or disagreement alongside each CHSP service recommendation in the assessor portal. An Assessment Delegate's decision to agree with the recommended CHSP services must be recorded in the Notice of Decision. If Assessment Delegates are approving the client for the CHSP classification only (that is, they are not approving any ongoing or short-term Support at Home classification), the assessor portal will not currently generate the *approval* version of the Notice of Decision. In this situation, Assessment Delegates will need to use the offline Notice of Decision (approval) template.

8.3.4. Step 4. Confirm the priority category

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

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

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

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

1. lives alone (1 point)

2. identifies as Aboriginal or Torres Strait Islander (1 point)
3. has an assessed cognitive impairment (1 point)
4. is experiencing homelessness or is at risk of homelessness (1 point)
5. requires urgent ongoing service provision (2 point)
6. has waited more than six months from the day they applied to access services, or applied for reassessment and lives in a rural or remote area (in a Modified Monash Model category 5, 6 or 7 area) (1 point)

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

Note:

Assessment Delegates will not know the priority category until after they click the 'Save and Delegate' button in the portal.

The four priority categories are as follows:

Table 46. Priority categories for ongoing Support at Home classifications

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

The Priority Category will be displayed under 'Approvals for a Client' in the Assessor Portal.

If an assessor makes changes to the following fields in an older person's client profile after the priority category has been calculated and the person has been placed in the queue, the system will automatically recalculate the priority category and queue position:

- Accommodation type
- No fixed address
- Lives With
- Aboriginal and Torres Strait Islander Status

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

As part of the assessment process, assessors are expected to have a clear conversation with the individual about whether they are seeking to receive services through the Support at

Home program. This helps ensure the individual's current needs are met and supports fair and timely access to services for others. When individuals who are not actively seeking services through the Support at Home program remain on the Support at Home Priority System, it can cause delays for those who are ready and actively seeking services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AT-HM scheme funding tiers

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

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

Funding tier	Funding allocation cap	Funding period
Assistive technology		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000[1] (nominal)	12 months
[1] Participants can access more than $15,000 with a prescribed need.		
Home modifications		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000	12 months[2]
[2] Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence is provided to Services Australia		
Other funding		
Assistance dog maintenance	$2,000 per year	Ongoing[3]
[3] Funding for assistance dog maintenance will be automatically allocated every 12 months; however, the funding cannot accrue or rollover.		

An AT-HM tier guide has been developed to assist assessors to make a funding tier recommendation for assistive technology and/or home modifications based on the older person's assessed need in the IAT. This includes considering their current functional ability and home environment. The guidance has been designed to consolidate the main elements of the IAT relevant to AT-HM to support assessors in choosing a funding tier. The guide will suggest a funding tier which should sit where the majority of tier indicators have been selected. Assessors should ensure their recommendations align with the participant's goals, safety, independence, and overall ability to remain living at home. They may choose to select an alternate tier if funding does not align with assessed need. Assessors can upload the document as an attachment to allow Assessment Delegates to review as supporting evidence for any funding tier recommendations made.

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

AT-HM list

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

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

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

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

The AT-HM list includes the following categories:

- managing body functions – including pressure cushions, anti-oedema stockings and memory support products
- self-care products – including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- mobility products – including walking frames, wheelchairs and lifting devices
- domestic life products – including assistive products for food preparation, eating, drinking and house cleaning
- communication and information management products – aids that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices
- home modifications - including accessible showers, grabrails, fixed ramps and safety barriers.

The AT-HM list

The AT-HM scheme guidelines

8.4.3. Step 3. Confirm the priority category

The AT-HM scheme has separate priority systems to the Support at Home Priority System, as the funding is separate. The AT-HM scheme has an Assistive Technology Priority System and a Home Modifications Priority System that allocate AT and/or HM funding. An older person assessed as eligible for AT and/or HM will enter the AT-HM Priority Systems in one

of its four priority categories (immediate, high, medium, standard). The older person will not be able to access AT-HM under Support at Home until funding has been allocated. The amount of time they wait for services will depend on the priority category they are in.

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

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

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

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

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

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

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

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

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

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

- **For clients <u>not</u> seeking AT and/or HM services through the Support at Home program**, the assessor should set the AT and/or HM service seeking preference to 'not seeking services'. This option makes sure the client **does not** enter the AT or HM Support at Home Priority Systems, and so is not allocated funding under the AT-HM scheme. Relevant circumstances include when:

- the client has chosen to access services through NATSIFACP or MPSP and so they do not require services from a Support at Home provider (or funding from the Support at Home program)
- the client does not want to access AT and/or HM services at this time.

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

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

An older person can change their service seeking preference by:

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

Note:

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

8.5. Approving AT and HM under CHSP

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

8.5.1. Understanding AT and HM under CHSP

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

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

Under the Act, eligible people will be approved for:

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

- the home modifications service group with a classification level of HM CHSP.

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

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

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

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

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

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

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

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

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

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

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

8.6. Approving permanent residential care

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

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

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

There is one key point to remember when deciding on access for older people who are **not** Aboriginal or Torres Strait Islander. **Section 68** of the Aged Care Act 2024 (the Act) requires these older people to have a continuing need for funded aged care services because of sickness in order to access the residential care service group. Assessment Delegates need to be satisfied, that the person's sickness at the time of assessment means that they have a continuing need for residential care.

8.6.2. Step 2. Confirm the priority category

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

Table 48. Priority categories for permanent residential care

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

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

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

8.6.3. Urgency rating for residential care

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

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

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

Table 49. criteria for urgency ratings for residential care

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

Urgency rating	Description
	Indicators: Some decline, minor falls, current supports are working, client prefers to delay move. **Example**: A client managing at home with informal support but thinking about future needs.

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

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

8.7. Approving residential respite care

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

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

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

There is one key point to remember when deciding on access for older people who is **not** Aboriginal or Torres Strait Islander. **Section 68** of the Aged Care Act 2024 (the Act) requires these older people to have a continuing need for funded aged care services (including nursing) because of sickness in order to access the residential care service group. This requirement is also applicable to time-limited approvals including residential respite care. As an Assessment Delegate approving an individual for residential respite care assessment, they need to be satisfied that an older person's sickness at the time of the assessment means they have a continuing need for residential care including nursing services for a limited period of time.

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

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

8.7.2. Step 2. Decide the classification level

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

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

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

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

8.7.3. Extensions for residential respite

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

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

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

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

(a) carer stress

(b) severity of the individual's condition

(c) absence of the individual's carer

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

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

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

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

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

8.8. Approving transition care

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

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

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

Transition care and the *Aged Care Act 2024*

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

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

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

- the classification type hospital transition for all three of the following service groups: home support, assistive technology and residential care

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

The table below summarises the possible approvals under the Act for hospital transition care. The Notice of Decision template will include all of these approval values and a prompting an assessment delegate to include them.

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

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

Access to transition care

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

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

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

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

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

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

Accessing residential care/residential respite and transition care

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

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

Duration of Transition Care

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

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

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

8.8.2. Step 2. Record the decisions

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

8.9. Other approvals and considerations

8.9.1. Alternative entry – giving approval after service commencement

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

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

In most cases, individuals who have accessed a service prior to an assessment would have accessed this service through the My Aged Care contact centre urgent services pathway.

Other circumstances may be emergency respite care and services provided by National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC) and Multi-Purpose Services Program (MPSP).

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

Note:

There may be instances where an individual may refuse to have an assessment if the urgent service has finished and they no longer require the service(s).

In this instance, the registered provider can make an application to the Assessment Delegate to approve the individual for the service(s) without an assessment under the exceptional circumstance provision at section 65(4) of the Act (see *Exceptional circumstances – approving a service without an assessment* later in this chapter).

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

NATSIFCAP and MPSP

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

An application can be lodged for access to Commonwealth subsidised services under the Act's alternative entry provisions via any of the available application pathways (e.g. Contact Centre, online referral or self-referral through an Assessment Organisation). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 30 days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

Residential care or residential respite care

Alternative entry pathways are available for individuals who require urgent residential care or residential respite care. To be eligible, at the time they accessed this care, there must have been a significant risk of harm to the individual if those services were not delivered before approval to access funded aged care services was given.

An application can be lodged for access to residential care or residential respite care under the Act's alternative entry provisions via any of the available application pathways (e.g. Contact Centre, online referral or self-referral through an Assessment Organisation) or by submitting the *Emergency Residential Care - Application for Care* form (see below). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 5 days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

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

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

If an older person and/or their active, active, appointed decision maker authorised under section 28(2) of the Act is unavailable, the registered provider may sign the form.

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

If a provider prefers the older person's appointed decision maker to sign the form, they may apply for an extension. Under **section 71** of the Act, an extension must be requested if the application cannot be submitted within the required timeframe.

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

When the form is received, the assessment organisation must:

- Ensure the form is signed by the older person, or their active, appointed decision maker, and confirm the *emergency case* section is completed correctly by the registered provider.
- Confirm the date the form was received. If it was submitted **after 5 calendar days** from the care start date, assessment can only proceed if the provider has been granted an extension by the System Governor, following an application for extension.
- Register and self-refer the older person in the My Aged Care assessor portal (if required and self-referral criteria are met).
- Assign intake priority. Although the person is already in care, the **Triage Delegate** must consider the urgency of the individual's circumstances. If the persons condition is rapidly deteriorating, the assessment should be scheduled as soon as possible.
- Upload the verified form to the older person's record.
- Schedule a comprehensive assessment with an assessor. Where possible, this should be face-to-face and collect information to:
  - Determine the older person's required level of care; and
  - Confirm that urgent circumstances existed at entry and that prior approval was not practicable.
- Record the Emergency Care start date (for residential care or residential respite) before sending to the Assessment Delegate.
- The assessor must collect as much information as possible about the urgent situation from the older person, their registered supporters (if available, and in line with the older person's will and preferences), their active, appointed decision maker/s (as relevant), the registered provider, and any other professionals involved at the time of entry.

Making a decision about alternative entry

Assessment Delegates are responsible for determining whether an older person who commenced care before applying for approval can be approved under alternative entry. To do this, they must ensure that the application process meets all relevant requirements described in this content, including, that the older person is eligible for the type of care being

provided, and that the care was urgently needed at the time it began. Assessment delegates must also be satisfied that it was not practicable to obtain approval before the care commenced (see circumstances described above). The decision must be based primarily on the care needs of the older person at the time they entered care.

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

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

Not all circumstances qualify as urgent. Situations such as a bed becoming available in a residential aged care facility, or a transfer from an acute care setting to another care environment, do not meet the criteria for urgent admission. If an assessment delegate determines that the older person did not urgently require care at the time of entry, but they are otherwise eligible, the application can still be approved, however the date of effect will be the date you make the decision.

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

Extensions

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

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

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

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

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

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

If an assessor believes the older person urgently needed care but the approval is already recorded in My Aged Care with a later date, they must initiate the **corrections process** to

backdate the approval. If the required backdating exceeds **42 days**, a correction cannot be made, and a reassessment is required.

8.9.2. Exceptional circumstances – approving a service without an assessment

An Assessment Delegate has the authority to approve access to funded aged care services without the individual undergoing a formal aged care needs assessment.

This is permissible if the Assessment Delegate is satisfied that there are exceptional circumstances justifying the decision. This will typically occur for a cohort that access funded aged care services through the alternative entry pathway but may pass away prior to receiving an assessment or refuse an assessment (particularly if they are receiving a time-limited service). An individual or a registered provider on their behalf must have submitted an application using the approved form, and no disqualifying conditions outlined by the rules should apply.

In a case where the older person has passed away, assessors should follow the *Client Deceased Before Assessment* process available through the My Aged Care assessor portal. This ensures the approval is properly recorded in the system and automatically submitted to **Services Australia**.

If there are complications preventing the use of the online process, an assessor should consult their Team Leader for advice.

Important:

Do not cancel the assessment in My Aged Care using the reason ‘client deceased’. This action changes the older person’s status to ‘deceased’ and locks the record as read-only, preventing an assessment delegate from recording an assessment decision.

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

Assessment organisations may also seek advice from the department, especially in cases where a person who has received funded aged care services but is refusing an assessment or where a significant delay between entry and application means the older person’s current needs no longer reflect their original circumstances–making a valid assessment difficult.

9. Chapter 9: Finalising the assessment and service referral

What you'll find in this chapter

This chapter includes guidance about:

- finalising the assessment
- recording and communicating the assessment outcome
- referring the older person for services, and supporting them to access services
- the single provider model for Support at Home (which includes a single referral code for all services/pathways)
- completing the Notice of Decision (approval/non-approval letter).

All sections in this chapter are new content

9.1. Overview of assessment finalisation

An assessment is finalised when:

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

An effective referral is where:

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

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

contact centre or the provider can send a Support Plan Review request to the assessment organisation if it is an appropriate request.

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

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

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

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

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

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

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

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

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

9.3. Recording and communicating the assessment outcome

A critical record of the assessment outcome is the Notice of Decision (sometimes referred to as the 'assessment outcome letter' or 'approval/non-approval letter').

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

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

The assessor must:

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

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

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

9.3.1. Notice of Decision of assessment outcome

Assessment Delegates have an obligation under the Aged Care Act 2024 (the Act) to issue a Notice of Decision to the individual within 14 days of making a decision. This notice must be issued after a first assessment, reassessment or Support Plan Review (SPR) and must clearly communicate:

- the outcome of the individual's assessment or reassessment/SPR, including decisions to approve or not to approve access to services,
- other decisions required under the Act, and
- the reasons for a delegate's decision and any other matters required under the Act.

For Assessment Delegates to meet their obligations under the Act, they must ensure that the notice sent to the individual satisfies the requirements in the following sections of the Act:

- **Section 70:** notify the individual about the decision regarding their access approval, including information on the approved service group(s), and the classification type(s) for the service group(s), any service types, and funded aged care services, and the date the access approval takes effect. The reasoning behind the decision and how the older person can apply for reconsideration if necessary must also be clearly explained. The section Reasons for Decision section gives more information on what must be considered and included in the reasons.

- **Section 79**: inform the individual about the classification decision, including the classification level for the approved service group(s), and when the classification level(s) did or will come into effect, and how they can apply for reconsideration if necessary.

- **Section 88:** If necessary, notify the individual about any priority category assigned to a classification type for a service group, clearly explaining the reasoning behind the decision and how they can apply for reconsideration if necessary. This is necessary to include it is decided that an individual should be approved for the following classification types for a service group:

    - ongoing for home support; or
    - ongoing or short-term for assistive technology; or
    - short-term for home modifications; or
    - ongoing for residential care

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

Note:
Decisions regarding a second unit of funding for the Restorative Care Pathway will require a separate letter to be generated.

There are two templates for the Notice of Decision:

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

- **Non-approval letter**: Used when the Assessment Delegate is **not** approving the older person for access to **any** services at first assessment or reassessment/Support Plan Review (SPR).

Unless the approval is for CHSP only, these templates can be generated in the My Aged Care Assessor Portal after decisions have been made and recorded. Much of the critical information is pre-populated and the templates include detailed guidance on how to complete a legally compliant letter.

Note:

For CHSP-only approvals, a separate 'offline' template that can be downloaded from the My Aged Care Assessor Portal must be used (see later in this chapter for more information).

To ensure the letter is tailored to the individual and includes all required legal information, Assessment Delegates will need to generate it (or download it for CHSP-only approvals) from the My Aged Care Assessor Portal, save it to their desktop, and make the necessary changes following the guidance text in the document.

As part of this, an Assessment Delegate must give reasons for their decisions in the Notice of Decision – further guidance on this is provided in the following sections.

When preparing the Notice of Decision letter, it is essential to include the Commonwealth Coat of Arms as a symbol of the Commonwealth government, along with the My Aged Care logo. Co-branding on letterheads is not permitted, and logos of individual assessment organisations must not be included, as specified in the contractual agreements between the Department and individual assessment organisations.

Reasons for decisions

Assessment Delegates must consider and record reasons for approval and non-approval decisions relating to service groups, service types or services. Assessment Delegates must turn their mind to these reasons when making approval decisions and then record them in the Notice of Decision.

Delegate decision reasons must:

- demonstrate how the individual meets or does not meet the criteria for approval under the relevant sections 65–68 of the Aged Care Act 2024 (the Act),
- be tailored to the person's specific circumstances, drawing on the information provided in the IAT and support plan,
- clearly explain (for approvals) how the individual satisfies the relevant eligibility criteria under the Act and the rules, with reference to their unique situation.

The Notice of Decision templates provide detailed guidance on how to record reasons that fulfil these requirements. Chapter 8 provides a comprehensive explanation of the eligibility requirements set out under sections 65-68 of the Act and the relevant rules.

Reasons for decisions: approvals

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

Reasons for approval decisions are recorded in the version of the Notice of Decision known as the 'approval letter'.

There are three reasons sections to choose from based on which section of the Aged Care Act 2024 (the Act) applies, the individual's circumstances and their approvals as follows:

Table 51. Summary of approval reasons sections of the Act and applicable circumstances of individuals

Section of the Act	Approval reasons section	Applies when:
Section 66	Section A *(Section B and C not required if this is chosen)*	• the older person is Aboriginal or Torres Strait Islander
Section 67	Section B *(most complex to complete – more info below)*	• the older person is **not** Aboriginal or Torres Strait Islander, **and** • the older person has been approved for the **home support**, **assistive technology** or **home modifications** service groups.
Section 68	Section C	• the older person is **not** Aboriginal or Torres Strait Islander, **and** • the older person has been approved for the **residential care** service group.

Section B of the Reasons for decisions – approvals section of the Notice of Decision is the most complex for the Assessment Delegate to complete. It includes a list of pre-defined reasons why an older person may need access to service types/services in the home support, assistive technology or home modifications service groups. The Assessment Delegate must choose the reasons that underpinned their decision to give access to these service types/services.

For further guidance, see *Specific reason/s why access is needed under Section 67* in section 7.6.3Chapter 7, which includes a mapping of service types/services to potential applicable reasons.

Reasons for decisions: non-approval

If one or more approvals were recommended by the assessor and/or requested by the older person but were **not** approved, the Assessment Delegate must provide reasons why they did not to approve access to the service group, service type or service. Relevant situations are summarised in the following table.

Table 52. Summary of situations relevant to non-approval of recommend and/or requested approvals

Situation	Applicable Notice of Decision template
A first assessment or reassessment/Support Plan Review where some of the services recommended or requested have not been approved (while others have been approved).	**Approval Letter**
A first assessment where the older person has been found ineligible to access to any services. A reassessment/Support Plan Review where no **additional** services have been approved.	**Non-Approval Letter**

For non-approval reasons the Assessment Delegate must:

- Consider how the individual's circumstances relate to the all the relevant eligibiltiy criteria set out in the Aged Care Act 2024 and the Aged Care Rules 2025 for the particular service.

For the older person to be considered eligible for a particular service group, service type etc, the Assessment Delegate must be satisfied that **all** of the relevant eligibilty criteria apply. If they do not meet all of the criteria – they cannot be approved.

- Use the free text sections to provide a brief summary of the reasons why the older person does not meet the eligibility criteria.

The Assessment Delegate must refer to the individual's unique circumstances and information in the assessment report (support plan). The Assessment Delegate must include details of how the individual's circumstances related to the eligibility criteria and therefore informed the decision not to approve.

The Notice of Decision templates prompt the delegate when free text description is required. They also include example text to demonstrate the level of detail Assessment Delegates must provide when completing the free-text section for non-approval reasons.

The letter templates account for the scenarios that are most likely to occur in practice. If the Assessment Delegate encounters a scenario that is not covered in the template, their Operational Manager can contact the department at myagedcare.assessment@health.gov.au for further guidance.

Assessment Delegates and Notices of Decision for CHSP

As part of the phased digital delivery process, both Clinical and Non-clinical Assessment Delegates will be required to produce the Notice of Decision 'off-line' (without system automation) for CHSP only approvals, but only Non-clinical Assessment Delegates will be required to produce non-approvals. The system automation that Clinical Delegates will be familiar with when producing a Notice of Decision for all other services except CHSP will not be introduced for CHSP only approvals until a later time.

Instead, Clinical and Non-clinical Assessment Delegates will use a template to complete this process. The Notice of Decision template is available under the 'Forms' tab in 'Reports and documents' tile of the Assessor Portal. To support this change, the department has issued a standalone fact sheet and video guidance on populating the letter itself..

The information Clinical and Non-clinical Assessment Delegates need to include in the letter will be clearly marked, and all required details will be available in the Assessor Portal. While the information for entry-level services like CHSP is less complex than that of Support at Home, it is still important that Clinical and Non-clinical Assessment Delegates review and transcribe the information carefully. Clinical and Non-clinical Assessment Delegates will need to provide reasons for their decisions within the Notice of Decision for CHSP, as they do for all services.

Uploading and sending the Notice of Decision

Once the Notice of Decision letter is finalised and signed, Assessment Delegates must upload it to the assessor portal (all documents must be uploaded in PDF format) for record-keeping purposes, and then post or email it to the individual (and their registered supporter/s and/or appointed decision maker/s, if applicable) using their preferred communication method/s.

Important:

The Support Plan needs to be included as an attachment whenever the Notice of Decision is sent. The Support Plan lists any approved service types and services, so it is legally considered part of the Notice of Decision.

The Referral Code letter also needs to be attached whenever approvals for CHSP services are given.

Providers can view the Notice of Decision and support plan via the My Aged Care Service and Support Portal.

Older people can also view their Notice of Decision, Support Plan and Referral Code letter (for CHSP approvals) via their My Aged Care Online Account. An older person's registered supporter/s (if any) may also be authorised to access this information.

In rare instances where the Assessment Delegate determines that no funded aged care services are required, the delegate will also need to send a Notice of Decision to the client to formally advise them of this outcome.

Note:

Older people who request/are recommended for the End-of-Life Pathway but are not approved *do not* receive a 'Non-approval letter'.

9.3.2. Notice of outcome of application for second concurrent unit of restorative care funding

If a Support Plan Review is being conducted and a second concurrent unit of restorative care funding has been requested, a letter must be sent to the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) notifying them of the outcome of the application for the additional funding.

The decision to approve additional funding to the Restorative Care Pathway episode is made under section 195-3 of the Aged Care Rules 2025.

The appropriate template can be found under the 'Forms' tab in 'Reports and Documents' tile in the Assessor Portal. This is a different template to the Notice of Decision issued after an assessment. Do not use the Notice of Decision you would usually use to communicate assessment outcomes.

Once finalised, the letter must be signed and uploaded to the assessor portal for record-keeping purposes, and then post or email it to the individual (and their registered supporter/s and/or appointed decision maker/s, if applicable) using their preferred communication method/s.

9.3.3. Registered supporters who are authorised to receive copies of letters

If an older person has a registered supporter/s who is authorised to automatically receive certain information or documents about an older person, they must be given a copy of the information or document. Registered supporters can access these documents if they have arranged their own login to the client portal via My Aged Care. If an older person has multiple registered supporters who are all authorised to receive copies of an information or document, each registered supporter must receive a copy. This includes a Notice of Decision.

Section 29 of the Aged Care Act 2024 (the Act) provides that any information or document that is required or authorised under, or for the purposes of, the Act to be given to an older person must also be given to their registered supporters if:

- the older person has consented to sharing this kind of information with their registered supporter, or
- regardless of whether the older person has consented, the registered supporter is a person covered by subsection 28(2) of the Act. That is, they are a registered supporter who is also an active appointed decision-maker for the older person.

These registered supporters are called ‘supporters’ and ‘supporter guardians’ in the assessor portal and app.

A registered supporter who is recorded as a ‘supporter lite’ cannot automatically be given information or documents about an older person. This is because the older person has not consented to that registered supporter receiving their information and documents under section 29 or the registered supporter is not a person covered by subsection 28(2) of the Act. That is, they are not a registered supporter who is also an active appointed decision-maker for the older person.

For example, assessors must not send a supporter lite a Notice of Decision. If a request has been made by a supporter lite to access a Notice of Decision letter, this should be escalated to the departmental team responsible for supporters.

9.3.4. Using electronic signatures

Under Section 10 of the Electronic Transactions Act 1999, electronic signatures can be used when a Commonwealth law requires a person’s signature. Assessment Delegates can use an electronic signature instead of a handwritten one.

However, before using an electronic signature, Assessment Delegates need to make sure that all legal requirements have been met under Section 10 of the Electronic Transactions Act 1999.

To do this effectively, follow these practices:

1. **Monitoring Use:** Set up procedures to track when their electronic signature is applied, so Assessment Delegates are always aware of its use.

2. **Administrative Assistance:** Assessment Delegates can get help from administrative staff to attach their electronic signature, but they should remember that the final responsibility for the notification remains with the Assessment Delegate. Administrative staff do not have the authority to apply the signature on their own.

Electronic Transactions Act 1999

9.4. Referral and support for service access

9.4.1. Referral codes

A referral code is a unique reference number used to connect an older person with a provider, enabling them to begin receiving services. Referral codes will be generated at different stages and through different mechanisms depending on the program recommended during the aged care needs assessment.

9.4.2. When to share referral codes

From 1 November 2025, all Australian government-funded aged care services fall under the *Aged Care Act 2024*. This includes CHSP services, which were not under the *Aged Care Act*

1997. This means that for all service approvals (including for CHSP), referral codes cannot be issued to the older person or service providers until the Assessment Delegate has completed and signed a Notice of Decision.

This is an important change that assessment organisations must adhere to, to ensure compliance with the *Aged Care Act 2024*. If referral codes are given to the older person and/or provider(s) and a Notice of Decision is ultimately *not* issued, this risks invalidating the assessment outcome. The Notice of Decision is the key legal mechanism that records a decision by the System Governor for the client to receive a funded aged care service.

The Notice of Decision does **not** include the referral code(s) for the recommended service(s). Referral codes displayed in the Support Plan can be used to reach out to as many service providers as preferred. The Support Plan must be sent as an attachment to the Notice of Decision. For CHSP service referrals, the referral code letter must also be sent as an attachment to the Notice of Decision.

9.4.3. Generating referrals/recommendations

An assessor must ensure that older people are referred to service providers according to service availability and the older person's needs and preferences.

Assessors may send referrals electronically to one or more government-funded service providers of the older person's choice or provide the older person with a referral code for the older person to self-manage the referral. The client can also ask for the code to be broadcast to several local providers to find availability.

Prior to sending the referral, the assessor must ensure that the older person (or their appointed decision maker, regardless of whether they are a registered supporter):

- consents to the My Aged Care referral method (broadcast, preference, or referral code)
- consents to the department providing information from the older person's My Aged Care online account to the provider for the purposes of the provider actioning the referral (including to provide the agreed service recommendation on the Support Plan.

9.4.4. Support at Home referrals

A single provider will oversee and deliver all Support at Home services (including ongoing services, short-term services through the Restorative Care Pathway, End-of-Life Pathway and AT-HM scheme) for a participant as able.

Under this model, registered providers will be required to hold registration that covers all services the participant will receive.

Note some providers may not be able to deliver all services a participant needs. Providers can choose to engage a third-party (associated provider) to deliver services on their behalf, however the provider remains responsible for delivery of services and compliance with relevant obligations.

If an older person prefers a particular service provider who does not have availability, the older person can elect to be referred to that service provider's waitlist on the system (if a waitlist is available). Older people can be on multiple waitlists at any one time.

A participant can change Support at Home providers at any time. Once a participant has chosen their provider, the provider will receive a referral in the My Aged Care Service and Support Portal.

Where a service provider is not available to meet the needs of the older person and the older person does not want to be put on a waitlist, the assessor should have a further conversation with the older person to consider other alternative options for support. Other options may include:

- a different service provider that could meet the need (on an interim or ongoing basis)
- non-Commonwealth-funded services; or
- the older person and/or their carer, registered supporter or other person who supports the older person being able to address their need.

Where required, the assessor is to provide short-term assistance to the older person for the purpose of implementing the Support Plan. This may include monitoring referrals or discussing options with service providers for the provision of alternative services if necessary, or in cases of providing for vulnerable older people, linking support or care coordination.

Referrals for Restorative Care Pathway, the AT-HM scheme and End-of-Life Pathway

If a participant receiving ongoing Support at Home services is referred to a short-term pathway (Restorative Care, the AT-HM scheme and End-of-Life), and their current registered provider does not deliver services under these pathways, the participant will be required to change providers to access their short-term pathway.

Assessors should ensure the individual is aware of this and confirm referral needs with the individual.

For further information see the Support at Home Program Manual.

Support at Home referral codes

The same referral code will be issued for every Support at Home (SaH) classification level (this includes ongoing and short-term services). This referral code will apply to all services approved under that classification level. The older person can present the referral code directly to their preferred provider or alternatively they can request assistance from the contact centre or the assessor for assistance in issuing a referral to a provider(s).

Referral codes are not listed in the Notice of Decision letter. Referral codes are generated and listed in the support plan in circumstances where a referral code is needed.

For an individual approved for an ongoing SaH classification or AT-HM, the referral code is generated once the individual has been allocated a place (and therefore funding) through the Support at Home, Assistive Technology or Home Modifications Priority Systems.

In circumstances where a participant is already receiving services from a SaH provider (for example, moving from the End-of-Life Pathway back to ongoing services), a referral code is not generated. In these circumstances a referral code is not required as the connection with a provider and access to the participant's record is already established through the initial use of the referral code.

For new Support at Home participants approved for the End-of-Life Pathway or Restorative Care Pathway:

- if a service referral has been made, the provider will contact the participant
- if no service referral has been made, the referral code will be displayed in the support plan.

If a participant is already receiving services and wants to change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code, enabling it to be used as a way to connect with a new provider. Alternatively, if the participant indicates during their assessment that they want to change providers and have the assessor make the service referral, the referral code can be found in the assessor portal.

9.4.5. CHSP referrals

Assessors should not issue CHSP referral codes until *after* the assessment delegate has approved the recommendation. An exception to this is the alternative entry pathway.

For CHSP services, a Support Plan may contain recommendations for multiple services within the same service type (e.g. Laundry, General House Cleaning and Shopping assistance services under the Domestic Assistance service type). The assessor will generate a separate referral code for each service type recommended.

If a service aligns with the older person's assessed needs and goals, assessors can issue more than one referral code for the same service type – allowing the person to access two services (sub-types) from two different providers, provided there is no duplication of service.

- For example, if an older person wishes to access services under the Social Support service type from two different providers (e.g. individual social support and group social support), the assessor should create two separate service recommendations using the 'Add a service recommendation' function. Each recommendation will generate a distinct referral code, ensuring that each provider receives a unique referral code
- For Allied Health and Therapy and Therapeutic Services for independent living service types, the assessor should always generate a separate referral code for each service recommended (e.g. separate referral codes for Physiotherapy and Occupational Therapy) as outlined above.

9.4.6. Residential care referrals

For residential (including through Multi-Purpose Service Program (MPSP)), the assessor can issue a referral code following the assessment and approval of services to enable the older person to take time to look for a suitable residential facility. Referral codes are contained within the client's support plan.

When selecting a residential aged care service provider to issue a referral to, assessors can use Star Ratings to help compare the quality of aged care facilities (not applicable for MSPS and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFAC)). Star Ratings are available via the 'Find a provider' tool on the My Aged Care website. All aged care facilities receive an overall Star Rating and ratings against Compliance, Residents' Experience, Staffing and Quality Measures).

Assessors can share a client's referral code with as many providers as the client chooses. A provider will use the referral code to view the client's approved services and specific

needs in the service and support portal. If the provider and client agree they will take a bed in the residential care home, a formal agreement will be exchanged between the parties, and the referral will be formally accepted in the My Aged Care portal. Once a provider accepts a referral and payments commence from Services Australia, all other open referrals will close.

My Aged Care - 'Find a provider' tool

9.4.7. Generation of referral codes for different programs and pathways

The table below provides further details regarding referral codes across the different approval pathways and programs.

Table 53. Guide for generation of referral codes for aged care programs

Aged care program	Pathways	Generation of a referral code
Support at Home program	SaH ongoing	Once the older person is allocated a place through the Support at Home Priority System, they will be sent a funding assignment letter containing their recommended services and the referral code for ongoing SaH services classifications 1 - 8. If a participant is reassessed to a higher ongoing classification the upgrade notice letter will contain a referral code. However, the participant does not need to take any action as the referral code will already be active with their provider. To change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code which can then be used to connect with a new provider. This follows the same pathway previously used in the Home Care Packages Program. Note: If the older person has previously been approved for the End-of-Life Pathway, a referral code is not generated
Support at Home	End of Life Pathway (EoL)	Referral code is generated into the Support Plan attachment provided to clients (if no service referral has been made AND the older person has not been approved for an ongoing Support at Home classification previously)

Aged care program	Pathways	Generation of a referral code
Support at Home	Restorative Care Pathway (RCP)	Referral code is generated into the Support Plan attachment provided to clients (if no service referral has been made and the older person has not been approved for an ongoing Support at Home classification previously). **Note:** If the current provider does not provide Restorative Care the older person will need to change providers. To change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code which can then be used to connect with a new provider.
Support at Home	Assistive Technology -Home Modifications (AT-HM) scheme	Once the older person is allocated a place through the Assistive Technology and/or Home Modifications priority system, they will be sent a funding assignment letter containing their recommended services and the referral code for their AT and/or HM classifications. This is the same referral code used for SaH ongoing, EoL and RCP classifications. If the participant is already receiving services from a Support at Home provider, they do not need to take any action as the referral code will already be active with their provider. Note: For the below circumstances, where AT-HM funding is allocated immediately, the participant does not receive a funding assignment letter.1. AT and HM short-term with RCP 2. AT short-term with EoL 3. AT ongoing, AT and HM short-term for participants who have been previously assigned the EoL pathway. 4. Approval for a higher AT or HM short-term tier through an SPR. If the participant is not already receiving services from a Support at Home provider, the referral code is generated into the Support Plan attachment.

Aged care program	Pathways	Generation of a referral code
Commonwealth Home Support Program (CHSP) National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) Multi-Purpose Service Program (MPSP)		CHSP, NATSIFACP and MPSP services will require assessment, delegate approval, and a Notice of Decision (letter outlining their decision) to be issued. The Support plan attachment provided to clients will include the referral code(s) for CHSP. MPSP and NATSIFAC (if no service referral has yet been made). For CHSP services, a Support Plan may contain recommendations for multiple services within the same service type (e.g. Laundry services, Shopping assistance and General house cleaning under the CHSP Domestic Assistance service type) **Note:** For Allied health and Therapeutic services for independent living Service types, referral codes should be generated and display at the service level in the Support Plan. For any CHSP referrals, these codes will also be contained in a separate Referral Code Letter which is sent to the older person for ease of access. **Note:** if older person consents to electronic notifications, the Assessment Delegate can send these letters via email.
Transition Care Program (TCP)		The hospital discharge staff will identify and liaise with a TCP provider to access these services using the referral code.
Residential Care		For residential (including through MPSP), the assessor can issue a referral code following the assessment and approval of services to enable the older person to take time to look for a suitable residential facility. Referral codes for residential care will be contained within the Support Plan attachment.

9.4.8. Steps an assessor must take

An assessor must:

- Check availability of service providers in the older person's region. Commonwealth funded service provider contact details can be accessed in the My Aged Care Service Finder. Service providers will find the name of an older person's assessing outlet in the 'Plans' tab of the older person's record.
- If required (e.g. for vulnerable older people) contact providers on behalf of the older person when referring.

- Add additional documentation in the 'Notes' to ensure all pertinent information is available to service providers.

- Consider all referral options (through portal by broadcast, preference, direct referral, or issue referral code) and the service priority (excluding support at home).
- Consider referrals/recommendations to services not listed in My Aged Care.
- Where service availability is limited, work with the older person to explore alternative options of support to meet their areas of concern and goals.
- Discuss and record carer information and advise older people and/or their carers of carer support options available including requesting a call back from a local Carer Gateway service provider or the National Dementia Helpline.

Assessors must ensure they are aware of appropriate care options within and outside Commonwealth funded aged care, such as local supports, health, community services and private services. To offer a broad range of strategies to assist the older person to achieve their goal, the assessor builds and maintains effective working relationships with service providers and extends connections with services and organisations in their local community, including those not listed in My Aged Care.

9.5. Corrections process

Assessment Delegates are responsible for ensuring that all recorded decisions are accurate and complete. Diligent quality checks are essential to minimise the need for corrections and maintain accurate records.

Despite thorough quality checks, errors may occasionally occur. If an assessment delegate identifies an administrative or typographical error after submitting a decision, it is essential to initiate the correction process promptly.

When an error is identified, assessment delegates must submit a correction request within 42 days of the original decision. The correction request will be forwarded to the department for consideration.

See Chapter 11 for more information about the corrections process

10. Chapter 10: Support Plan Reviews and reassessments

What you'll find in this chapter:

This chapter provides guidance around the circumstances for conducting a Support Plan Review (SPR) or a reassessment for each aged care program.

The majority of this chapter includes new information

10.1. Reassessments under the *Aged Care Act 2024*

Section 64 of the *Aged Care Act 2024 (the Act)* provides for aged care needs reassessments. A reassessment may be required when an individual's circumstances have changed.

In the Act the term 'reassessment' is used as an umbrella term to describe both SPRs and reassessments. An individual may request a reassessment if they believe their aged care needs have changed, or it may be identified through a scheduled SPR.

Note:

In this manual, the term 'reassessment' is used to describe an assessment that occurs after an older person has already been assessed at least once.

SPRs are used as a mechanism to adjust an older person's aged care services without needing to undertake a reassessment. In some cases, the Assessment Delegate may approve access to services based on updated information through the SPR process.

A reassessment will be required when there are *significant* changes to a client's needs or circumstances.

Significant changes in care needs and circumstances require higher-level of care or different types of care (and/or changes to priority).

For example, an older person approved for ongoing Support at Home at the Classification 4 level who requires a higher classification level of package (e.g. Level 5) due to increased care needs or a change in priority for home care service must first undertake a reassessment by an assessor and approved by an Assessment Delegate.

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

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

The Triage Delegate will determine whether an individual is eligible for a reassessment.

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

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

Refer the user guide on how to conduct SPRs within the My Aged Care portal.

10.1.1. Support Plan Reviews (SPRs)

The introduction of Support at Home expands the circumstances in which an SPR can be undertaken.

SPRs are most likely initiated by the older person's provider (with the older person's consent), who can submit a request through the My Aged Care service and support portal. When requesting SPRs, providers must attach supporting documentation about the participant's current care arrangements, such as their quarterly budget and/or care plan.

Alternatively, an older person or provider can ask for a SPR when:

- the older person's needs, goals or circumstances have changed,
- they need additional services that are not on their support plan, or
- a time limited service has ended.

An older person can request a SPR through My Aged Care or from a Services Australia Aged Care Specialist Officer. A SPR may lead to:

- no changes to the support plan as it meets the person's needs
- updates to the support plan to address changed needs; or
- a reassessment due to significant changes.

Where someone has made a request on behalf of the individual receiving the aged care service, it is important that the assessor confirms that the individual has consented to this occurring when beginning the SPR.

Team leaders are responsible for accepting an SPR and assigning it to an assessor. The assessor will review the information provided and determine whether the older person's updated needs can be addressed through a SPR or if a reassessment is required.

If the SPR is valid, any proposed changes to the Support Plan will require a decision by an Assessment Delegate. If a reassessment is required, the referral will proceed through the

standard triage and assessment process, with new recommendations subject to delegate approval.

A key change which aims to reduce the need for SPRs is the flexibility of service recommendations in the IAT for any Support at Home classification. When an assessor accepts the Support at Home recommendation for a client, all services in the list will be pre-selected, with the exception of *Allied Health and Therapy* and *Therapeutic Services for Independent Living* service types. This is due to the specific nature of these services and should only be recommended if an older person has a need for those services.

10.1.2. Key principles of a Support Plan Review

An assessor may set a review date on the Support Plan at the time of the assessment or initiate the review on an ad-hoc basis. Unplanned/ad hoc reviews may be requested by the service provider or through the contact centre or ACSOs.

- The SPR may be completed over the phone with the older person, their appointed decision maker, or in line with the older person's will and preferences, their registered supporter.
- Assessors are best placed to make the decision as to whether an older person requires a reassessment following a review. This decision is supported by the information provided by the older person, the contact centre, service providers and health professionals.
- All SPRs are required to go through a delegate for approval.
- The My Aged Care contact centre has the ability to issue a direct referral to the assessment organisation for an urgent comprehensive assessment for residential care, residential respite care or transition care.
- If appropriate to the older person's aged care needs, a non-clinical assessor can create an assessment referral after starting the SPR.
- If an older person is admitted to hospital, it is best practice for an SPR to be conducted once the older person is discharged from hospital and there is a clear picture of the care needs and type and level of support that will be required.
- If an urgent referral is required before discharge, the SPR can be conducted in the hospital setting. This may mean that the referral needs to be transferred to an assessment organisation that is contracted to conduct assessments in a hospital setting (limited to State and Territory Governments). Alternatively, the assessor may contact the state or territory assessment organisation to self-refer directly.
- Where there is a significant change in an older person's needs or circumstances which affect the objectives or scope of the existing Support Plan, a reassessment may be undertaken. A reassessment can be the outcome of a SPR.

If not already scheduled earlier, a SPR may be routinely scheduled 12 months from the last assessment for older people with ongoing CHSP services in place. A reassessment is only required for significant changes in care needs or circumstances since the last assessment. The service provider is responsible for reviewing client services at least every 12 months.

- When conducting an assessment, assessors should be considering the current needs of the older person and not recommending services that aren't supported by the assessment.
- An unplanned SPR will replace the scheduled review in the system, and if necessary, can be re-scheduled at the completion of the unplanned review.
- An older person can have multiple reviews of their Support Plan linked to the same assessment.

- If new WHS information is recorded on the Support Plan following a SPR for an existing older person, the assessor should advise the provider of the new information so the provider can make the appropriate risk-based determination of how best to support the older person's service delivery.

Once a support plan review has been commenced, an assessor will be able to make changes to information in the following sections of the older person's Support Plan:

- Assessment summary
- Older person motivations
- Goals & recommendations, including recommendations for linking support & reablement.
- Manage services & referrals
- Associated People
- Review

It is important for the assessor to keep in mind that generated support plans can include goals and concerns from all previous assessments. The assessor should remove and/or update previous goals to ensure the focus remains on the older person's current goals and aspirations as per their most recent assessment and/or SPR.

Prioritising Urgent SPRs

While no priority category for SPRs exists as it does for assessment referrals (outlined in Chapter 4) assessors should consider prioritising SPRs where there is an identifiable urgent need. In particular, assessors should prioritise:

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

Otherwise, all other SPRs should be completed within calendar 15 days from the date the SPR referral is accepted.

10.1.3. Outcome of the SPR

After conducting the SPR, the assessor should consider possible outcomes, including: determining that no changes to the Support Plan are required (as it meets the older person's needs), updating the current plan, or conducting a reassessment.

The assessor can record the outcome to 'complete' the SPR and 'finalise' the SPR when it has been completed. If the SPR outcome is a reassessment, then the assessor is prompted to issue the assessment referral. The SPR referral will appear above the Assessment Summary Information in the older person's Support Plan.

Note:

A SPR should accurately reflect the review details, including date, attendees, mode, assessor name, reason for SPR and the outcome of the review (up to 1000 characters).

Assessors must ensure the older person or active, appointed decision maker (whether or not a registered supporter) agree to the details entered in the outcomes field as these comments will automatically appear on the older person's Support Plan.

The Assessment Summary section of the Support Plan has a 5000-character limit which can also be updated with the SPR. All past versions of the Support Plan are retained on the My Aged Care system and are a record of any deleted content.

After selecting 'complete & finalise Support Plan review' no further changes can be made. Where applicable (e.g. if new services have been added or if a decision has been made to not approve a specific request), a Notice of Decision will be required to be prepared for Delegate approval and shared with the older person.

The assessor may determine that the older person's needs or circumstances have changed significantly since their original assessment, and a reassessment is required.

10.1.4. Reassessments

An older person may require a reassessment following a SPR in the following instances:

- the older person has multiple new needs or significantly increased needs
- the older person requires a different service group (i.e. client receiving CHSP needs to move to Support at Home) the My Aged Care assessor portal allows a reassessment referral where:
- the SPR request meets one of the four defined scenarios only (transition care, residential care, residential respite care and older person relocation) or

- if the request does not meet the defined scenarios and the SPR clearly needs to be converted to a reassessment, the assessor can issue a reassessment referral where they select 'A reassessment required' as the outcome of the SPR or

- after the full SPR is completed and finalised, the assessor has the option to start a reassessment referral if this is appropriate.

Where the SPR outcome does not indicate a reassessment is necessary, but the person (or their active, appointed decision maker, whether or not a registered supporter) continues to request a reassessment, assessment organisations should be aware that making a decision not to proceed with a reassessment process is a reviewable decision under the Act.

If the triage delegate's clinical opinion (based on guidance materials and evidence) is that a comprehensive assessment is not required, the assessment organisation must ensure the older person:

- is aware of, understands and accepts this decision.

- is provided with the updated support plan which details the outcome of the SPR and if applicable, references the reason/s to the older person why the requested reassessment is not required at this stage; and
- is provided with information on how to request a further SPR should the older person's care needs or circumstances change.

If the older person does not accept the decision, then the assessment should proceed.

Reassessment of a classification level

Depending on the classification type for the service group, an individual or a registered provider acting on behalf of the individual may have the right to apply for a reassessment of a classification level under section 82 of the Aged Care Act 2024. Section 82 outlines who may apply for a classification reassessment for each classification type for a service group and when an application may be made. This is outlined in the table below.

Table 54. Circumstances when a classification reassessment can be sought

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
Ongoing or short-term for home support, assistive technology or home modifications	The individual	If: • the classification type is in effect for the individual; and • the individual considers a different classification level in the classification type for the service group should be approved; and • the funded aged care services are not being delivered under a specialist aged care program; and • it is considered the circumstances (if any) prescribed by the Aged Care Rules 2025 (the Rules) apply.
Ongoing for residential care	The individual A registered provider on behalf of the individual	If: • The registered provider is delivering ongoing funded aged care services to the individual through the service group in an approved residential care home; and • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • the funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply:

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
		• if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(2) of the Act in that time period; • it is considered the circumstances (if any) prescribed by the Rules apply.
Short-term for residential care	The individual The registered provider on behalf of the individual	If: • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • an access approval is in effect for the individual for the classification type for the service group; and • if the application is made by the registered provider: • the registered provider is delivering short-term funded aged care services through the residential care service group to the individual in an approved residential care home; and • those funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: • if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(3) of the Act in that time period; • it is considered the circumstances (if any) prescribed by the Rules apply.
Hospital transition (for any service group)	A registered provider on behalf of an individual	All of the following apply: the registered provider is delivering hospital transition funded aged care services to the individual through the service group; and • the registered provider or the individual considers that an extension of the period of effect for the classification level that is in effect for the individual for the classification type for the service group should be approved for the individual.