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

If the application meets the necessary criteria, the assessor will complete a reassessment. The Assessment Delegate will decide whether to approve a different classification level for the classification type for a service group or an extension of the classification level (if relevant) under section 78 of the Act. All new decisions will be documented in a new Notice of Decision letter.

10.1.5. Criteria for SPRs and reassessments by program

The table below describes the circumstances in which a SPR is required versus a reassessment.

Table 55. Circumstances when an SPR is required versus a reassessment

Program	Support Plan Review	Reassessment
Ongoing Support at Home 1-8	Approval for additional service types, or for additional services within the prescribed service types that have already been included in the support plan and is within the current SaH classification. This can be submitted by the older person's Support at Home provider.	An older person's circumstances have changed significantly that is likely to mean that they will require a higher classification level, with more frequent or a different type of funded aged care service. e.g. the individual's caring arrangements have ceased, permanently, to provide some or all care to the individual; or the individual has experienced an event, or a decline in their condition.
Restorative care	Approval for additional service types, or for additional services within the prescribed service types that have already been included in the support plan during the restorative care episode, or to provide evidence that a second unit of funding is required (may consider availability of units).	To meet changing needs of the older person which may include needing an ongoing service type after an episode of restorative care has finished (or during the period if circumstances change).
AT-HM	Changes to existing AT and/or HM funding tiers AT funding tier to access repairs or maintenance of an item listed on the AT-HM list. Addition of new AT and/or HM funding tiers for transitioned HCP recipients with insufficient HCP unspent funds (from November 2025).	Where there has been a significant change in needs which may include the individual requiring a higher ongoing Support at Home classification level or a different type of funded aged care service including a new need for AT and/or HM.

Program	Support Plan Review	Reassessment
End-of-Life Pathway	Request an urgent SPR to be assessed for End-of-Life Pathway if the person already has a Support at Home classification. Request an urgent SPR to move to an ongoing SaH. classification if the person needs services beyond the End-of-Life Pathway funding period.	A person who does not have a Support at Home classification will need a reassessment to be approved for the End-of-Life Pathway.
Residential care- (permanent)	N/A	Clients needing residential care who have not had residential care added as a care type to their support plan.
Residential care- (respite)	N/A	Clients needing residential care who have not had residential care added as a care type to their support plan.
TCP	N/A	If the client receiving other aged care services enters hospital and needs TCP, a reassessment is required.
CHSP	To meet changing needs which may require additional CHSP services. To close off a period of reablement support and/or meet changing needs which may include needing an ongoing service type after episode of reablement has finished.	If a CHSP participant needs access to a different service type that they are not currently approved for. For example, Support at Home or residential respite care, a reassessment is required.
MPSP	If a client is receiving other aged care services and an MPSP service recommendation needs to be added.	New MPSP clients will require an assessment from 1 November 2025. If an existing MPSP client who had not previously been assessed (who were deemed across under transitional arrangements) needs to move to mainstream services, a reassessment should be undertaken.
NATSIFACP	If a client is receiving other services and a NATSIFACP service recommendation needs to be added.	New NATSIFACP clients will require an assessment from 1 November 2025. If an existing NATSIFACP client needs to move to mainstream services and

Program	Support Plan Review	Reassessment
		hasn't been assessed before, a reassessment should be undertaken.

10.1.6. SPRs for Aboriginal and Torres Strait Islander assessment organisations

SPRs will usually be reallocated to the previous assessment organisation. As Aboriginal and Torres Strait Islander assessment organisations commence, an Aboriginal and Torres Strait Islander client may wish to transfer their SPR to an Aboriginal and Torres Strait Islander assessment organisation. In this case, the assessment organisation is expected to support a warm transfer of the assessment referral.

10.1.7. SPRs for AT-HM

Participants accessing assistive technology (AT) or home modifications (HM) can request an SPR:

- to seek a higher AT or HM funding tier
- to seek AT funding to meet their assistive technology repair or maintenance needs
- to seek allocation of an AT or HM funding tier if they are a participant with a transitional Support at Home classification (from November 2025).

Note:

If transitional clients don't have unspent funds or have insufficient unspent funds to meet their need for assistive technology and home modifications, they can agree for their providers to supply information indicating any additional funding needs through the AT-HM scheme data collection process.

This is a direct pathway where the department delegate may allocate an AT ongoing and/or AT/ HM low, medium or high short term funding tier.

This process will be available from 1 November 2025 until February 2026, and should be followed in the first instance before seeking an SPR.

The following will require a reassessment:

- to allocate an AT or HM funding tier for the Restorative Care Pathway
- to allocate an AT funding tier for End-of-Life Pathway

If an SPR is requested for a higher AT or HM funding tier or for repair and maintenance of assistive technology providers will be required to submit evidence, along with the SPR request, for the aged care assessor to review:

- a valid prescription (if applicable) and
- a quote indicating costs of AT repairs or maintenance needs

10.1.8. SPRs for Restorative Care Pathway (RCP)

Restorative care partners can submit a SPR for several reasons related to the RCP including:

- Request approval for additional services which were not approved at assessment but are required to meet goals identified in the Goal Plan
- Request approval for additional unit of RCP funding to be accessed concurrently (subject to unit availability)
- Request a reassessment due to changing needs

Like other classifications, a provider can submit a SPR requesting additional services to ensure goals can be met.

Second unit of funding for Restorative Care Pathway

Under subsection 195-3A of the Aged Care Act 2024, an older person may access an additional unit of funding for use during their 16-week episode. Please note this is not a reviewable decision.

Access to a second unit of funding is requested through a SPR. A Clinical Assessment Delegate will need to consider written evidence provided to determine approval (refer to Chapter 6 for information on manual oversight of RCP units/places). Evidence includes written confirmation from a medical practitioner, registered nurse or allied health practitioner, or restorative care partner of the registered provider that the individual requires additional funding to access nursing care and allied health and therapy services to achieve restorative care outcomes as detailed in the goal plan. Further supporting evidence can include the goal plan, clinical assessment tool outcomes, and individualised budget. Where an older person is already receiving ongoing services, information should be provided to demonstrate adjustments to ongoing services is also not sufficient to achieve restorative outcomes in combination with their initial RCP unit of funding. Availability of RCP units may also be considered.

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 SPR request.
    - However, the assessor 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 and may be informed by the availability of RCP funding units.
- When a request for a second unit of RCP is received assessors should confirm if there is approval for STRC and RCP on the client's record. If there is approval for

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

Important: Second units of funding are counted as part of RCP cap management. Assessors and Assessment Delegates should stay informed of any communications from the Department's Assessment Delivery Section regarding RCP units when recommending and approving a second unit of funding.

For more information on the Restorative Care Pathway please refer to the Support at Home Manual.

Recommending ongoing services after/during a period of Restorative Care Pathway

Assessors should consider any potential needs after exiting from the RCP, it may be necessary to undertake a reassessment for ongoing funding towards the end of the RCP episode.

The intention of Restorative Care Pathway (RCP) is to improve levels of function and delay the need for ongoing or higher levels of ongoing aged care services. This can only be determined after the RCP episode has been completed. The restorative care partner could request a reassessment if it is anticipated ongoing services may be required or there has been a change in circumstances.

Important: Assessors should carefully consider the timing of reassessment during a RCP episode. Approval for an ongoing/new ongoing Support at Home classification will remove RCP access.

SPRs for the End-of-Life Pathway

SPRs are used in the context of the End-of-Life Pathway for the following reasons:

- For existing Support at Home participants, to move from their current ongoing Support at Home classification to the End-of-Life Pathway
- For participants accessing the End-of-Life Pathway who require services beyond the End-of-Life funding period, to move from the End-of-Life Pathway to an ongoing Support at Home classification

In both cases above, the SPR should be marked as an 'urgent' SPR.

Funding under the End-of-Life Pathway can be used for a maximum of 16 weeks. An urgent SPR can be requested any time after 12 weeks if it appears the participant will require services that exceed the End-of-Life funding period. The SPR will enable the participant to:

- Return to their previous ongoing Support at Home classification, if they were already receiving services under Support at Home, or

- Transfer to the ongoing classification that was determined at assessment, in the case of participants who were new to Support at Home when they commenced the End-of-Life Pathway.

It is critical that SPRs to transfer a participant from the End-of-Life Pathway to ongoing services are prioritised in order to ensure there is no break in continuity of service. If a participant is returning to an ongoing Support at Home classification that is considered insufficient for their needs, a reassessment may be needed. However, the SPR to return the participant to their current ongoing classification should be completed first, in order to ensure funding is made available. After this, a reassessment can be requested.

Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews

My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review

11. Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints

What you'll find in this chapter:

This chapter provides information on assessment related reviewable decisions in accordance with the *Aged Care Act 2024 (the Act)*. It also details:

- the reconsiderations process
- the corrections process
- options for reviews and revocations
- the pathways that clients can take to submit complaints and raise concerns about their My Aged Care experience.

The primary audience for this section is assessors, team leaders, delegates and operational managers. Assessors should be aware that they are providing a valuable and trusted public role in the delivery of quality aged care assessment services on behalf of the Commonwealth. A necessary part of a quality assessment is having supporting processes that allow the older person the right to complain without fear of reprisal, while also upholding the statement of rights and principles.

11.1. Reviewable decisions

The Act broadens the scope of reviewable decisions related to the assessment process. It is essential for all delegates to be aware that certain decisions can be reviewed, and to ensure that every decision made is thoroughly documented and supported by evidence.

Section 557 of the Act outlines the decisions made by the System Governor that are subject to review, including those related to assessments and assessment-related activities. This section also identifies the specific entities affected by each reviewable decision.

An affected entity for a reviewable decision is a party that has the right to seek a review of a decision. To find out whether a person is an affected entity in relation to a reviewable decision refer to column 2 of section 557 of the Act.

An older person's registered supporter/s can communicate the decision of an older person to seek a review of a decision. It is not the role of a registered supporter to make decisions for an older person. If an older person has an active, appointed decision maker, that person may make a decision on behalf of an older person to seek a review of a decision. They may only do this if this decision is within the scope of their legal authority and that legal authority is active.

11.1.1. Reviewable decisions related to assessment

Table 56 is an excerpt of the table in Section 557 of the Act relating to decisions made by the System Governor that relate to assessment.

Table 56: Reviewable decisions made by the System Governor that relate to assessment

Item	Decision	Simplified explanation	Entity
7	A decision under subsection 57(1) not to make an eligibility determination for an aged care needs assessment for an individual	Deciding that an individual is not eligible for an aged care needs assessment	The individual (the older person)
8	A decision under subsection 64(1) that a reassessment of an individual's need for funded aged care services is not required	No need for reassessment: Deciding that an older person does not need a support plan review or reassessment of their aged care needs	The individual (the older person)
9	A decision under subsection 65(1) that an individual does not require access to funded aged care services	No need for aged care services: Deciding that an older person does not need funded aged care services	The individual (the older person)
10	A decision under subsection 65(2) not to approve a service group, or a classification type for a service group, a service type, or a funded aged care service, for an individual	Not approving certain services: Deciding not to approve a service group, service types or services, or classification types for an older person	The individual (the older person)
11	A decision under subsection 65(4) that exceptional circumstances do not apply in relation to an individual	No exceptional circumstances: Deciding not to approve access where an older person has not	Each of the following: (a) the individual (the older person);

Item	Decision	Simplified explanation	Entity
		undergone a needs assessment.	(b) the registered provider
12	A decision under subsection 71(2) to not specify an earlier day in a notice of decision under section 70	Not setting an earlier date: Deciding not to backdate the date of approval in the notice of decision for an older person.	The individual
13	A decision under subsection 71(6) to reject an application for a longer period for an individual to make an application	Rejecting a longer application period: Deciding not to give an older person more time to submit an application to have their date of approval backdated	The individual (the older person)
14	A decision under subsection 74(1) to revoke an eligibility determination for an aged care needs assessment for an individual	Revoking eligibility for an assessment: deciding to cancel an older person's eligibility for an assessment	The individual
15	A decision under subsection 74(1) to revoke an access approval for an individual	Revoking eligibility for aged care: Deciding to cancel an older person's eligibility for aged care services	The individual (the older person)
16	A decision under subsection 78(1) to establish a classification level for an individual for a classification type for a service group	Setting a classification level: Deciding on a classification level for an older person for a specific classification type in a service group	Each of the following: (a) the individual; (b) if a copy of the notice of the decision is required to be given to a registered provider

Item	Decision	Simplified explanation	Entity
			under subsection 79(3)—the registered provider
17	A decision under subsection 83(1) to change a classification decision (the original decision) for an individual	Changing a classification decision: Deciding to change a previous classification decision for an older person	Each affected entity for the original decision
18	A decision under subsection 86(1) to assign a priority category for a classification type for a service group	Assigning a priority category: Deciding on a priority level for an older person for a specific service group	The individual
19	A decision under subsection 90(1) to change a decision about an individual's priority category for a classification type for a service group	Changing a priority category: Deciding to change an older person's priority level for a specific classification type for a service group	The individual (the older person)

11.2. Reconsiderations process

If an affected entity is not satisfied with a decision that is reviewable under the Aged Care Act 2024 (the Act), they are encouraged to first contact their assessment organisation to discuss their concerns in the first instance. The affected party may also submit a written **reconsideration request within 28 days** of receiving the decision notice to:

The System Governor
Department of Health, Disability and Ageing
Attn: Review of Decisions Section
GPO Box 9848
ADELAIDE SA 5001

This request must set out reasons why they are seeking a review. The System Governor can allow further time for someone to make a request for reconsideration (see subsection 559(3)(c) of the Act.)

The reconsideration will be conducted by an internal decision reviewer who is different from the original decision-maker, holds equal or higher position and was not involved in the making of the original decision.

The internal decision reviewer will be a departmental delegate of the System Governor and will carry out a comprehensive administrative review of the original assessment organisation's decision.

They will consider all relevant information, including new evidence from third parties before making a determination. They must also, within 14 days of receiving the request, provide the affected entity written notice that the request has been received and when it was received. The notice must also set out that if the internal reviewer has not provided notice of their decision within 90 days of receiving a request, the original decision has been affirmed.

The internal decision reviewer must make a decision within **90 days** after receiving the request. They may:

- Affirm the original reviewable decision.
- Vary the original reviewable decision.
- Set the reviewable decision aside and make a new decision.

After making their decision, the internal decision reviewer must give written notice of the following to each affected entity for the reviewable decision:

- the reconsideration decision;
- the day the reconsideration decision was made;
- the reasons for the reconsideration decision;
- details of the affected entity's right to apply to the Administrative Review Tribunal for review of the reconsideration decision.

If the affected entity is still not satisfied after the reconsideration, they may apply for a further review by the Administrative Review Tribunal.

11.2.1. The role of assessors in reconsiderations

During the reconsideration process, the Departmental delegate will discuss the request with the assessor through the assessment organisation's Operational Manager. This step helps clarify any matters related to the case.

Assessment organisations play a vital role in the reconsideration process. They will be invited to provide additional information in response to the person's claims, including the rationale for their decision making, which will be carefully considered as part of the administrative review.

11.2.2. New point in time assessment

If the Internal Review Officer identifies that there has been a significant change in the older person's circumstances since the original decision, they may discuss with the older person, the option of pursing a reassessment and withdrawing their review request.

If the older person decides to withdraw their review request, the Department will facilitate the reassessment and cease to deal with the matter.

Important: The Department cannot discontinue the review process unless the older person chooses to withdraw their application.

If the older person decides to pursue a new point-in-time reassessment, the Internal Review Officer will instruct the assessor to conduct a reassessment.

11.2.3. Supplementary off-line assessment by assessment organisation to inform the reconsideration process

When a review officer determines that a supplementary off-line assessment is required to support a review decision, they may request that it be undertaken. This scenario typically arises when it appears that an incorrect decision may have been made, but the Internal Review Officer requires updated information to determine the most appropriate assessment outcome. The outcome of this assessment will contribute to the body of evidence considered as part of the review process. This process is distinct from a reassessment, because a reassessment stems from a change in circumstances. In the case of a reassessment, the outcome would not be backdated to the time of the original assessment. Requests for off-line supplementary assessments are infrequent and are only made when necessary to support a thorough and fair reconsideration process.

Through the Assessment Organisation's Operational Manager, the Internal Review Officer will request the off-line supplementary assessment in writing. It will be necessary to use the paper-based version of the Integrated Assessment Tool (accessible from the My Aged Care assessor portal) or other form as specified by the Internal Review Officer.

The off-line supplementary assessment is usually performed by an assessor who was not involved in the original decision or by a different assessor from the same organisation. To ensure a comprehensive evaluation, the reassessing assessor can collaborate with the original assessors, the original Assessment Delegate, and any other relevant parties as needed.

The assessor must not discuss the supplementary off-line assessment outcome with the older person or any other party in any way after completing the assessment. The outcome of the supplementary off-line assessment is not recorded in My Aged Care by the assessment organisation. Instead, it is shared with the Department through the Assessment Organisation's Operational Manager.

11.3. Further avenues of review

If affected entities remain dissatisfied with the outcome of the review, they can apply to have their reconsideration decision reviewed by the Administrative Review Tribunal (ART) and the Commonwealth Ombudsman.

If an affected entity has concerns about the way a decision was made or the processes involved, they can make a complaint to the Commonwealth Ombudsman.

11.3.1. Administrative Review Tribunal (ART)

If a person who has requested a reconsideration of a decision is not satisfied with the outcome, they may apply to the ART for a further review. It is important to note that there is a cost to the applicant for initiating this process.

Assessment Delegates must ensure that all information used in making approval decisions, including any data gathered during reviews of reviewable decisions is properly maintained and readily available for review by the ART.

Both the Departmental delegate and the Assessment Delegate who made the original decision may be required to appear before the ART as part of the review process.

11.3.2. Commonwealth Ombudsman

The Commonwealth Ombudsman is responsible for considering the administrative actions and decisions made by Australian Government agencies. The Commonwealth Ombudsman will not make a fresh decision on the matter, rather they will consider the way a decision was made and make recommendations on how the decision or process could be improved.

The Ombudsman's office handles complaints, conduct investigations, performs audits and inspections and carries out specialist oversight tasks to determine whether the actions and decisions of agencies are wrong, unjust, unlawful, discriminatory or unfair.

The older person, or any person supporting them such as their carer, advocate or registered supporter, can contact the Commonwealth Ombudsman through the official website to raise their concerns or file complaints.

11.4. Revocations

Triage and Assessment Delegates are not delegated the power to consider or decide to revoke an older person's eligibility or approval decisions. These delegated powers are exercised by department delegates (delegates employed directly by the department).

11.4.1. Revocations on the initiative of the System Governor

There are specific circumstances where an approval or eligibility decision may be revoked. One scenario is that during the assessment or application process the individual gave

information or documents and those information or documents were false or misleading, omitted any matter or thing that without would make the document false or misleading. This can include situations where key facts presented during the assessment process were inaccurate or misleading, resulting in the approval or eligibility decision being granted erroneously. In such cases, it is the departmental delegate's responsibility to assess the evidence and, if warranted, initiate the revocation process to maintain the integrity of the aged care system.

Decisions to revoke an eligibility determination for an aged care needs assessment and access approval for an individual are reviewable decisions under Section 557 of the Aged Care Act 2024.

If an assessor or assessment delegate has concerns about the information or documents provided by an older person and/or their registered supporter(s) or appointed decision makers, they should contact the Department at AssessmentReovactions@health.gov.au

Before making a final decision to revoke eligibility or access approval, the Departmental delegate must follow the structured process outlined under the Act. The Departmental delegate must first notify the individual in writing that a decision to make a revocation is being considered. The notice must clearly state the reasons why a revocation is being considered and invite the individual to make written submissions about the matter within 14 days of receiving the letter (or a longer period if specified). Additionally, the notice must inform the individual that the Departmental delegate may proceed with the decision after considering the submissions.

If an individual has made their submission, the Departmental delegate is required to carefully consider them before making a final decision. This ensures that the individual's perspective and any relevant information are taken into account, allowing for a transparent and fair assessment of the situation.

If, after considering the submission, the Departmental delegate deicides to revoke the eligibility determination or access approval, they must notify the individual in writing within 14 days of making the decision. The notification must include the decision itself, the reasons for the decision, and information on how to apply for a reconsideration if the individual wishes to challenge the outcome.

If an eligibility or access approval is revoked, any pending applications related to the individual are automatically withdrawn. This means the individual will need to reapply for access if they wish to receive funded aged care services.

11.4.2. Requests on the initiative of the individual

Approvals can be revoked if the individual themselves requests it. Under section 72 of the Act, an individual has the right to request the revocation of an eligibility determination or an access approval if it is currently in effect. This option to withdraw an eligibility approval is only available if the individual is under the age of 65 at the time of making the request. The request for revocation must be submitted using the approved form to ensure that the process is formally documented and consistent with legislative requirements. Once a valid request for revocation has been made, the System Governor is obligated under section 73 to revoke the eligibility determination or access approval within 28 days of receiving the request. The decision must be communicated to the individual within 14 days of being made in the form of a written notice. This notice should clearly outline the revocation decision, including any relevant reasons and implications.

Note:

Once an approval or eligibility determination is revoked, any pending applications related to that individual under section 56 or 64 are automatically considered withdrawn.

This means that no further action will be taken on those applications.

Additionally, approvals lapse automatically if they are superseded by a subsequent decision. This occurs when a new eligibility determination or access approval replaces the existing one, rendering the previous approval invalid. In these cases, the revocation happens implicitly because the new decision takes precedence.

11.5. Corrections process

Assessment delegates are responsible for ensuring their decisions are recorded accurately and completely. Diligent quality checks are essential to minimise the need for corrections and maintaining accurate records.

If an administrative or typographical error is identified after submitting a decision, assessment delegates must promptly initiate the corrections process. As an example, errors could include an omission of funded care types from an individual's approval that were recommended in the Support Plan and the delegate intended to approve; or entering an incorrect approval date of effect that does not match the actual approval date of effect.

Where an error has been identified, an assessment delegate must request a 'correction' **within 42 days of the original decision**. Corrections should be requested via the 'Decision History' tab in the My Aged Care Assessor Portal using the 'Request Changes to care approval decisions' button. Additional information that does not fit in the free text field should be forwarded to the department for consideration, via email at the following address: SASP.Reconsiderations@Health.gov.au.

The reason for the correction must be recorded when lodging the request. For example, "*Ongoing residential care omitted from online approval process, evidence of an ongoing residential care recommendation in Support Plan*". For the department to agree to the correction, the assessment delegate's intention (as at the time the decision was made) should be clearly evident though assessment documentation and/or other supporting documents on My Aged Care.

If the assessment information is not consistent with the correction request, the department will reject the request. In instances where a client's needs change after the original decision, it is required that a reassessment is undertaken.

In situations where the Assessment Delegate has reconsidered their decision and changed their mind after recording the approval (based on additional information they have received), a correction request is not appropriate, and a reassessment is required. Any correction requests received by the department for this reason will be rejected.

A correction cannot be requested where service referrals have been issued for services. Where a correction is required for an assessment and service referrals have been issued, the assessment organisation must recall all services in an 'issued' state before they can request a correction.

If it is identified a correction is required after a service referral has been accepted or services have commenced, the correction should be escalated to the department via email at the following address: SASP.Reconsiderations@Health.gov.au

11.6. Complaints

Older people (and/or their carer/advocate/registered supporters) have the right to raise their concerns about the information, service or care they have received from My Aged Care, their assessor or service provider.

There are different ways to make a complaint depending on the part of My Aged Care that the concern relates to, such as:

- the My Aged Care Contact Centre
- aged care assessment with an assessor
- the outcome of an aged care assessment
- the care and services received from a service provider; or
- the conduct of a registered supporter.

11.6.1. Concerns about My Aged Care

An older person or registered supporter should discuss their concerns about the service or information they receive from My Aged Care with the contact centre in the first instance.

If they are unable to resolve the issue, My Aged Care will provide a reference number to track the progress of the complaint. A person can make a complaint by:

Calling My Aged Care on 1800 200 422.

Posting their complaint to:

My Aged Care Complaints
PO Box 1237
Runaway Bay QLD 4216

An assessor can make a complaint or escalate an issue about contact centre services by calling the My Aged Care Service Provider and Assessor Helpline on 1800 836 799.

If an older person, assessor or provider is not satisfied with the response received, they can take further action by sending an email with the detail of their complaint, and their My Aged Care reference number to: myagedcaresupport@health.gov.au

11.6.2. Concerns about the assessment

Assessment organisations are required to have a complaints procedure in place.

If a person has concerns about their assessment, they are advised to contact the assessor or their assessment organisation in the first instance.

If the department receives a complaint through My Aged Care it will be referred to the relevant assessment organisation for investigation and/or resolution. The assessment organisation will report back to the department on the outcome.

If the person cannot first resolve the issue with their assessor or their organisation, they are advised to call My Aged Care for assistance on 1800 200 422. Complaints relating to assessment organisations are escalated to the department for investigation.

My Aged Care Complaints and

My Aged Care Quality in Aged Care

11.6.3. Complaints about an aged care provider

If an older person (and/or their carer/advocate/registered supporter/appointed decision maker) is unhappy with any aspect of the care or services being received through an aged care provider they can:

- Speak to their service provider about their concerns
- make a complaint to the Aged Care Quality and Safety Commission (ACQSC):
    - By calling 1800 951 822
    - By completing an online form on the commission's website
    - In writing to:

        Aged Care Quality and Safety Commission
        GPO Box 9819, in your capital city

An assessor can also make a complaint with the ACQSC if they have concerns about an aged care provider.

In addition to the above, complaints about care received from Multi-Purpose Service Program (MPSP) providers or Transition Care Program providers can be referred to the relevant state and territory health department complaints bodies.

MPSP providers also have an obligation, under their MPSP agreement with the Commonwealth, to ensure their respective state or territory is advised when complaints have been made by an individual about the aged care or health services being delivered.

ACQSC: Aged Care Service Provider Complaints

ACQSC: Lodge a Complaint

11.6.4. Complaints and concerns about registered supporters

Any person or organisation can raise a complaint or concern with the System Governor relating to a registered supporter's conduct, including alleged non-compliance with the duties of a registered supporter. The System Governor can suspend and/or cancel the registration of a supporter. This may occur at the request of an older person or registered supporter, or at the initiative of the System Governor.

Complaints or concerns can be raised by anyone. This includes an older person, their other registered supporters, appointed decision makers, aged care providers or workers, medical

or allied health practitioners, advocates or any other person who is concerned for the welfare or treatment of themselves or the older person.

Assessors have a role in raising or handling complaints, concerns, or requests to cancel the registration of a supporter by escalating any relevant information to the departmental delegate responsible for supporters. This includes any request from an older person or their registered supporter to cancel the relationship where the circumstances mean the registered supporter may be suspended under the Aged Care Act 2024 (the Act), or any other complaint or information that suggests a registered supporter is not complying with their duties under the Act. This includes anything an assessor notices at an assessment.

Complaints about aged care providers, including their engagement with registered supporters, can be made to the ACQSC.

11.6.5. Complaints about aged care policies

Complaints related to Australian Government aged care policies, guidelines or decisions should be referred to the Department of Health, Disability and Ageing.

12. Chapter 12: Supporting diverse experiences and needs

What you'll find in this chapter

This chapter outlines the ways in which the aged care system supports an older person's diverse needs by ensuring they have access to person-centered aged care assessments and services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences. Persons of diverse needs includes older people who are:

- Aboriginal and Torres Strait Islander people
- People from culturally and linguistically diverse backgrounds
- People who live in Remote and Very Remote areas
- People who are Financially or Socially Disadvantaged
- Veterans
- People who are Homeless or at Risk of being Homeless
- Care Leavers
- Parents separated from their children by Forced Adoption or Removal
- Lesbian, Gay, Bisexual, Trans, Intersex, and other Gender Diverse people (LGBTI+)
- Are an individual with disability or mental ill-health
- Are neurodivergent
- Are deaf, deafblind, vision impaired or hard of hearing
- Other Groups (People with Dementia, palliative care needs etc.

12.1. Supporting diverse needs during an assessment

The Department of Health, Disability and Ageing, Australian Government agencies, aged care assessment organisations, providers and the aged care workforce must ensure that older people have access to person-centred aged care assessments and services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences.

The Aged Care Diversity Framework provides guidance for an accessible aged care system for every older person.

The Statement of Principles in section 25 of the Aged Care Act 2024 (the Act) provides for an aged care system that offers accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed aged care services, based on the needs of the individual, regardless of their location, background and life experiences. This may include individuals who:

- are Aboriginal or Torres Strait Islander persons, including those from stolen generations
- are veterans or war widows
- are from culturally, ethnically and linguistically diverse backgrounds
- are financially or socially disadvantaged
- are experiencing homelessness or at risk of experiencing homelessness

- are parents and children who are separated by forced adoption or removal
- are adult survivors of institutional child sexual abuse
- are care-leavers, including Forgotten Australians and former child migrants placed in out of home care
- are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or are gender diverse or bodily diverse
- are an individual with disability or mental ill-health
- are neurodivergent
- are deaf, deafblind, vision impaired or hard of hearing
- live in rural, remote or very remote areas.

It is important to understand that individuals may identify across more than one group and may have a variety of special and diverse needs that will need to be recognised and taken into consideration.

During the assessment process, assessors must consider how they can create a safe assessment setting and ensure older people have a trusted support person present if needed. This may be a carer, partner, registered supporter, friend or perhaps a member from their 'family of choice' (who may or may not include biological family). This will help to build trust and ensure that an assessor can collect all information necessary to develop an appropriate and tailored Support Plan with the older person that considers their diverse needs.

It is important to recognise that many older people with diverse needs, characteristics and life experiences may have experienced exclusion, discrimination and stigma during their lives and may not feel safe to reveal such potentially sensitive information in an assessment.

Aged Care Diversity Framework

12.2. Understanding cultural safety for older Aboriginal and Torres Strait Islander people

Assessors are required to complete an introduction to cultural safety as part of the induction training through MAC Learning to ensure they understand why cultural safety is important in providing safe aged care experiences for older Aboriginal and Torres Strait Islander people.

The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council's (NATSIAACC) definition of cultural safety (referenced below) was co-designed in 2024 and included in the revised explanatory memorandum accompanying the Aged Care Bill 2024. All workers in the aged care system, including assessment staff, are expected to critically self-reflect and take responsibility for building an understanding of how they can improve their approach to culturally safe care in their daily practice.

It is also required that assessment organisations provide their staff with additional cultural safety and trauma aware, healing informed training relevant to the customs and protocols local to the area in which they operate. Further to this, itis recommended that assessment staff undertake additional training on how to understand and support the Stolen Generations. As at 2022, all Stolen Generations survivors are aged 50 or over and therefore may be eligible to receive aged care services. Many Stolen Generations survivors live in urban and

regional locations where there are few, if any Aboriginal and Torres Strait Islander community controlled aged care services and facilities.

When assessing Aboriginal and Torres Strait Islander clients, it is important to be guided by the individual's preferences, and observe body language and respond respectfully. If appropriate, assessors are encouraged to tailor their assessment approach to the specific needs of individuals to ensure that their support requirements are accurately reflected in their support plans. This may include:

- using a trusted cultural broker, or advocate,
- using supplementary assessment components of the IAT that are best suited for assessing the older person's needs, and/or
- developing relationships that support regular interactions and mentorship with existing and trusted health services and specialist providers located within a local community.
- Working with existing Aboriginal Community Controlled Organisations (ACCOs) Aboriginal Community Controlled Health Organisations (ACCHOs) affiliates and Indigenous organisations who specialise in providing aged care services where they are available.
- Using the Kimberley Indigenous Cognitive Assessment (KICA) assessment tools and the Good Spirit, Good Life guide in the Integrated Assessment Tool (IAT) for older Aboriginal and Torres Strait Islander people. These have been validated as the most acceptable and reliable instruments for assessing the needs of Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander aged care | Australian Government Department of Health, Disability and Ageing

The KICA and the Good Spirit, Good Life guides are in the IAT User Guide

NATSIAAC definition of cultural safety

'Cultural safety requires understanding of one's own culture and the impact that your culture, thinking, and actions may have on the culture and wellbeing of others through ongoing critical self-reflection.

Only the care recipient themselves can determine whether the service is culturally safe. Ensuring access to a culturally safe, respectful, responsive and racism free aged care system is inherent for the optimal safety, autonomy, dignity, and absolute wellbeing of Aboriginal and Torres Strait Islander Elders, senior and older people, their families and community.

Aged care service providers and workers must take responsibility for building trust and relationships with Aboriginal and Torres Strait Islander service users, and their families, and for creating a new aged care system which centres on their living experience, cultural, and ageing needs, as determined by Aboriginal and Torres Strait Islander service users themselves.

The implementation of a trauma aware, healing informed approach to professional practice, and facilitating a greater understanding and respect for individual and collective cultures, histories, knowledges, traditions, stories, and values of Aboriginal and Torres

Strait Islander service users, their families and communities, will greatly support the delivery of a quality and culturally safe aged care system.

Aged care service providers must also firmly commit to continuously measure and improve structures and behaviours necessary for cultural safety and quality support to remain embedded in the Australian aged care system'.

12.3. Cultural safety for other cohorts

Cultural safety is an important consideration for all culturally distinct groups, for example culturally and linguistically diverse and lesbian, gay, bisexual, trans/transgender, intersex+ communities. It's important for assessors to recognise and respect the identities and customs of all older people who are culturally different from themselves, to provide equitable outcomes and quality assessment services.

Respecting a person's identity, culture and diversity in aged care should focus around understanding their individual needs and preferences and providing an assessment that is reflective of and responsive to their social, cultural, linguistic, religious, spiritual, psychological, medical and other needs, including cultural safety.

Assessments for all older people, regardless of culture or background, should be conducted in a way that is:

- **Welcoming and open-minded:** an assessor truly listens to the older person and works from the older person's cultural perspective, rather than their own
- **Respectful:** recognises their cultural identities and customs and does not challenge, assault or deny the identity of the older person
- **Safe, inclusive and flexible:** meets the older person's needs, expectations and rights, and is supportive of diverse characteristics and life experiences
- **Collaborative:** shares meaning, knowledge and experience through meaningful dialogue between the older person and the assessor
- **Self-determined:** provides choice, participation and control to the older person, and allows them to make decisions about matters that affect them

Aged Care Diversity Framework action plans | Australian Government Department of Health, Disability and Ageing

Partners in Culturally Appropriate Care (PICAC)

Working with Diverse Groups in Aged Care

Australian Migrant Resource Centres

12.3.1. Aboriginal and Torres Strait Islander assessment organisations

As a part of the Single Assessment System, Aboriginal and Torres Strait Islander assessment organisations began being rolled out from August 2025. These assessment organisations provide a choice for older Aboriginal and Torres Strait Islander people seeking

access to a culturally safe aged care assessment. A small number of organisations will commence providing these services initially and over time, these services will extend their reach and progressively cover more areas across Australia.

A culturally safe assessment process will help to improve the experience for older Aboriginal and Torres Strait Islander people and increase their uptake of aged care services. This will support them to maintain their independence at home for longer.

The organisations will help older Aboriginal and Torres Strait Islander people, their families, and carers, to access aged care services across urban, regional, and remote Australia.

Aboriginal and Torres Strait Islander assessment organisations will:

- Take a less formal yarning approach to assessments to make the older Aboriginal and Torres Strait Islander person feel comfortable.
- Undertake face-to-face assessments, where possible. This could be in the older person's home, at a community centre, or outdoors at a place of the older person's choosing.
- In line with the older person's wishes, welcome the presence of the older person's family member, advocate or registered supporters, to be part of the meetings.
- Allow for multiple visits, if required, to build trust and develop a relationship.
- Be embedded within the local community. Connecting with the local community with their knowledge of local services, customs and protocols will allow them to support matching appropriate assessors to the older person's preferences and needs.
- Be supported by connection to community to gather information about the older person's health and wellbeing to understand the aged care services they need prior to meeting them. This will limit the amount of information that the assessor needs to draw from the assessment, which will help to limit the number of times that the older person needs to re-tell their story.
- Maintain a connection with the older person for the whole journey to receiving services, through Elder Care Support workers. This will help to manage any uncertainty or questions throughout the process.
- Work with organisations that support Stolen Generation survivors.
- Provide interpreting services when needed.

Until an Aboriginal and Torres Strait Islander service is available in their area, older Aboriginal and Torres Strait Islander people can receive aged care assessments via an existing assessment organisation. Once an Aboriginal and Torres Strait Islander organisation becomes available, older Aboriginal and Torres Strait Islander people will have the choice to be assessed through either assessment pathway.

More information available at - Aboriginal and Torres Strait Islander Aged Care Assessment Organisations.

12.4. People with dementia

Under the Statement of Rights in section 23 of the Aged Care Act 2024 (the Act), an individual has a right to equitable access to an assessment in a manner that is accessible and suitable for individuals living with dementia or other cognitive impairment.

The Australian Government recognises the unique needs of people with dementia and their families, registered supporters or other people who support them, and representatives.

Assessors should foster links with dementia-specific services, including Dementia Australia and Dementia Support Australia (DSA), and where relevant, include this expertise in the assessment process. This will facilitate an understanding of how best to communicate with older people with dementia. It will also assist assessors to better understand the needs of people living with dementia and their care partners, families, and representatives, and assist to improve linkages, integrated care, and access.

Assessors should be particularly alert to concerns about cognitive impairment or people who indicate a previous diagnosis of dementia. Referrals to the National Dementia Helpline or a GP should be considered where concerns about cognitive impairment are raised or where there is a diagnosis of dementia but the person, their registered supporters or other people who support them are not receiving the dementia-specific support they need. Assessors can request a call back for people or their carers who have concerns about dementia (with their consent) from the National Dementia Helpline through the Assessor Portal and the Aged Care Assessor App. A trained professional from Dementia Australia will then call the older person and speak to them about dementia-specific services and supports that might be of assistance.

Note:

A person does not need to have a formal dementia diagnosis to be referred to the National Dementia Helpline.

People living with dementia can experience behaviour changes, known as behavioural and psychological changes of dementia (BPSD), which impact their care and quality of life. Personalised support services are available from Dementia Support Australia (DSA) to help carers and service providers anywhere nationally to develop strategies that optimise function and support unmet needs for people impacted by BPSD and assessors can make referrals for support (with appropriate consent of care network as relevant) via DSA's 24-hour helpline or online.

Assessors must use their professional judgment if an older person has dementia or is cognitively impaired. In these cases, the input of registered supporters or other people who support the older person and/or advocates is particularly important.

Note: assessors should be aware that applying professional judgement might be especially difficult when working with Aboriginal and Torres Strait Islander older people and older people from Culturally and Linguistically Diverse backgrounds living with dementia or cognitive impairment. Factors such as language barriers, different concepts around ageing and dementia, a lack of awareness of dementia among family members and the additional stigma attached to dementia in some cultures can all make assessment more complex. Some culturally appropriate dementia resources are included under further information below.

Assessors may find the *Clinical Practice Guidelines* and *Principles of Care for People with Dementia* (the Guidelines) useful. The Guidelines provide recommendations for the diagnosis and management of dementia and are intended for use by staff working with people living with dementia in the health and aged care sectors, including GPs. Assessors can refer to the IAT user guide on how to answer some questions through the lens of an older person with cognitive difficulties such as dementia (e.g. physical mobility). Assessors are required to complete a Dementia specific training module in MAC Learning as part of their training.

Companion documents to the Guidelines include a Health Professional Quick Reference Guide, and for people living with dementia and their carers the *Diagnosis, treatment and care for people with dementia: A consumer companion guide.*

Dementia Australia website:

Resources for Aboriginal and Torres Strait Islander communities

Dementia Support Australia website:

Nationwide, 24-hour dementia carer support | Dementia Support Australia

Department of Health, Disability and Ageing website:

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

What we're doing about dementia | Australian Government Department of Health, Disability and Ageing

University of Sydney (Cognitive Decline Partnership Centre) website:

Clinical Guidelines for Dementia

12.4.1. Training and tools for health and aged care professionals

- Accredited training, education, upskilling and continuing professional development for the workforce providing dementia care in the primary, acute, and aged care sectors is available through Dementia Training Australia.
- The Wicking Dementia Research and Education Centre at the University of Tasmania offer two online courses known as MOOCs (Massive Open Online Courses): Understanding Dementia and Preventing Dementia.
- A Dementia Outcomes Measurement Suite (DOMS) provides tools for the assessment of various aspects of dementia.

Dementia Australia website: Culturally Appropriate Dementia Assessment Tools

Dementia Training Australia website: Dementia care training, education and resources for health and aged care professionals

University of Sydney (Cognitive Decline Partnership Centre) website:

Assessment process diagram for dementia diagnosis

Dementia Centre for Research Collaboration (DCRC) website:

Dementia Outcomes Measurement Suite (DOMS) - Tools for the assessment of various aspects of dementia

University of Tasmania website:

Understanding and Preventing Dementia, Massive Open Online Course

12.5. People who live in remote and very remote areas

A small number of older people live in isolated areas. These locations are classified using the Modified Monash Model (MMM). Whilst recognising face-to-face assessment is good practice and should be the first option, this mode of assessment is not always possible for older people living in remote areas. In these circumstances, assessments may be conducted using non-face-to-face technologies such as telephone or telehealth. Where this occurs, a suitably qualified person from within the local health service or community care provider should be present to support the older person and to facilitate the assessment.

Assessors should develop and maintain good working relationships with health and community workers in rural and remote communities who may be called upon to assist with assessments and provide information and community needs and local services.

12.6. People who are financially or socially disadvantaged

Financial or social disadvantage can often create a significant barrier for people to access a wide range of services in the community. Assessors should ensure that they develop and promote links with organisations in their area which attempt to overcome these barriers and provide assessments to people who may benefit from services regardless of their financial or social circumstances.

People who are financially or socially disadvantaged may also experience difficulties in accessing services after their approval. Assessors should be prepared to engage in a wide range of care coordination activities on behalf of older people to ensure that they receive the care which they need and to which they are entitled.

From 1 November, financial hardship arrangements will continue to be available if an older person can't afford to contribute to the cost of their aged care, both in residential care and in-home care. An older person will be assessed on their specific circumstances. If approved for hardship assistance, the Australian Government will pay some (or all) of their aged care fees. The government will pay any approved amounts to the aged care provider on the older person's behalf. If an older person is required to pay some of their fees, they will continue to pay those to their provider.

To apply for financial hardship assistance, an older person must meet certain requirements and complete the Aged Care Claim for Financial Hardship Assistance form. This form is sent to Services Australia to assess the application and they will let the older person know in writing of their decision and what assistance they are eligible for. This form should be submitted by an older person once they start accessing aged care services.

Hardship assistance for aged care – Fact sheet

Financial hardship assistance | My Aged Care

12.6.1. Veterans

The Australian Government recognises the aged care needs of the veteran community, in particular, mental health issues including post-traumatic stress. This is creating demand for a wider range of health care and support services in residential and home care services.

Assessors should establish links with relevant veterans' organisations in their communities and develop links between veterans and home care and residential care services. They should aim to facilitate an understanding of veterans' particular needs and to improve integrated care and access.

Assessors should have a good understanding of services provided by the Department of Veterans' Affairs (DVA) including the Veterans' Home Care (VHC) Program, the Coordinated Veterans' Care (CVC) Program and other mental health and rehabilitation programs.

Assessors should advise veterans that if they are an Australian former prisoner of war or Victoria Cross recipient, DVA will pay their basic fee and means tested care fee. They still may need to pay a means tested accommodation payment if their income and assets are above a certain limit. Services Australia will take into consideration DVA compensation payments when assessing a person's income and assets under the Support at Home program.

Optional learning for all assessors called 'Supporting older Australians, people with disability and Veterans' is available through MAClearning.

Department of Veterans' Affairs website

12.7. People who are homeless or at risk of becoming homeless

Assessors have a responsibility to recognise older people who are experiencing, or are at risk of becoming homeless, and to ensure that they can access an assessment and any aged care services approved for them. Liaisons between assessors and support services for homeless people are particularly important for this cohort because of their extreme vulnerability. Assessments for this cohort will require a flexible and unique approach by assessment organisations. For example, assessors may need to travel to outreach locations in order to undertake the assessment, working closely with the providers already linked to

the older person, such as community health clinics, hospitals, emergency housing providers or other community services such as those that provide free meals and laundry services.

People aged 50-64 seeking aged care services under the homeless or at risk of homelessness criteria must meet the appropriate definition as described in Chapter 1.

Assessors should also be aware that homelessness alone is not grounds to approve an older person as eligible for residential or other forms of aged care. The person must meet the eligibility criteria set out in the *Aged Care Act 2024*.

Where housing assistance services are not available, assessors should make appropriate referrals and work with their state and territory government housing and homeless services.

Learning for all assessors called ‘Homelessness and older people’ is available through MAClearning.

For further detail on the definition of homelessness in aged care, see Chapter 1 ‘Homeless or At Risk of Homelessness Eligibility’.

12.8. Care leavers

The department’s website provides information on care leavers, including a description of the term ‘care-leaver’.

This term refers to children who were in institutional and other out-of-home care prior to the year 2000, including:

- Forgotten Australians - people who spent a period of time as children in children's homes, orphanages, and other forms of out-of-home care prior to the year 2000.
- Former child migrants - children who arrived in Australia through historical child migration schemes and were subsequently placed in homes and orphanages.
- Stolen Generations - children of Aboriginal and Torres Strait Islander descent who were removed from their families and communities by federal and state government agencies from the late 1800s to the 1990s.

Assessors should be particularly sensitive to the effects of care-leavers’ childhood experiences with government officials, authorities and institutional care. These individuals may have experienced complex trauma and have general distrust of institutions and Government departments. Assessors should consider how to best support older people in the most sensitive and respectful way with an awareness and understanding of how childhood experiences may influence their concerns, preferences and decisions in relation to aged care, and emphasise that older people can have a support person at the assessment and that they are not obliged to take up any approved care.

In December 2016, the ‘Caring for Forgotten Australians, Former Child Migrants and Stolen Generations resource was launched. This package is designed to enhance aged care services and ensure residential and home care providers provide the best possible care to the care leaver groups. Additionally, the Real Care the Second Time Around Project has developed practical tips to assist aged care providers and staff to engage with Forgotten Australians/Care Leavers.

Important:

Under Support at Home, individuals who are care leavers are eligible for a care management supplement which will be credited to their provider's care management account.

To identify individuals who are eligible for a care management supplement during the assessment, assessors must use the diversity fields in the IAT, which do not currently capture care leavers.

Assessors who have identified individuals who are care leavers during the assessment should select the diversity field 'a person separated from your parents or children by forced adoption or removal'.

This will ensure Services Australia is able to identify these individuals from the assessment and apply a care management supplement to their provider's care management account. Refer to the Support at Home Program Manual for more information on care management supplements.

Department of Health, Disability and Ageing website: Caring for Forgotten Australians, Former Child Migrants and Stolen Generations Information Package

Helping Hands website: Real Care the Second Time Around – Practical Tips

12.9. Parents separated from their children by forced adoption or removal

This term refers to the policies and practices that resulted in forced adoptions and the removal of children throughout Australia, particularly during the mid-twentieth century.

Forced adoption practices impacted a large number of Australians and caused significant ongoing effects for many people, particularly mothers, fathers, and adoptees.

Assessors need to be particularly sensitive to those older people who have been adopted or impacted by past forced adoption practices, including interactions with government officials, authorities, and institutional care, as these experiences can have significant personal and psychological impacts. Assessors should emphasise that older people' wishes are taken into account, they can have a support person at the assessment, and they are not obliged to take up any approved care.

Department of Social Services website: Families and Children; Forced Adoption Practices and Forced Adoption Support Services

12.10. Lesbian, gay, bisexual, trans, intersex and other gender diverse people (LGBTI)

In Australia, the acronym 'LGBTI' refers collectively to people who are lesbian, gay, bisexual, trans and gender diverse, and/or intersex. LGBTI is often viewed as and referred to as single category that is used to speak about people using broad generalisations. However, LGBTI communities are not homogenous. Within the LGBTI acronym are several distinct, but sometimes overlapping, demographics each with their own histories, experiences and health needs.

Older LGBTI people and elders are likely to have experienced violence, stigma and discrimination throughout their lives. As a result, they may be reluctant to disclose their identities or histories to aged care services and therefore remain isolated or invisible within both the sector and the broader community. Combined with general stigmatisation and invisibility of LGBTI needs at large, this results in a lack of awareness of the unique needs of older LGBTI people, including a lack of targeted services to support them. In addition, the fear of mistreatment or rejection from aged care providers can lead to older LGBTI people delaying seeking care until their health deteriorates or a crisis occurs.

Assessors should ensure they conduct a non-judgmental assessment and the choice to disclose sexual orientation, sex/gender identity or variations of sex characteristics is entirely the older person's decision. Where an older person does disclose this information, the Assessor should emphasise that their information is protected information under the Aged Care Act 2024. In the case of transgender and intersex older people, where specific medical history may need to be communicated to service providers, it is important to discuss the way this information will be communicated or shared with providers.

Assessors should also be aware of service providers who provide LGBTI-specific services and those that are LGBTI inclusive and be prepared to advocate for LGBTI older people with other service providers as necessary as part of their care coordination activities.

In 2019, Actions Plans to Support LGBTI Elders were developed under the Aged Care Diversity Framework to address the unique needs and challenges faced by older LGBTI people. The provider action plan sets out what aged care providers can do to deliver inclusive care that is appropriate and sensitive to the needs of older LGBTI people. The consumer guide helps older LGBTI people to express their needs when speaking with aged care providers. It can also help people working in aged care to better understand the needs of LGBTI people.

Department of Health, Disability and Ageing website:

Actions to Support LGBTI Elders: A Guide for Consumers

Actions to Support LGBTI Elders: A Guide for Aged Care Providers

Working with Diverse Groups in Aged Care

Federal Register of Legislation website: Aged Care Act 2024 - Federal Register of Legislation (see Statement of Principles section 25)

12.11. Other groups

12.11.1. Carers

It is important for assessors to recognise the valuable contribution and informal support that carers provide in the care of older Australians.

Where possible, with the older person's consent, the assessor should involve the older person's carer, family, registered supporters or other people who support the older person in the assessment and support planning process. In assessing the older person's care needs where family and carers are involved, assessors may find there is a need to balance the older person's concerns and preferences with those of their family and/or carers. Assuming the older person has capacity to make their own decisions, only the goals and preferences of the older person should be reflected in their Support Plan. The assessor may need to meet with the older person separately to ascertain the older person's preferences.

Assessors should (with the older person's consent) gain an understanding of the carer's support preferences for the older person and their capacity to continue in the caring role. Assessors need to consider the carer's circumstances and assess if there are any factors that may affect the sustainability of the caring role. An older person may agree to service recommendations that also benefit the carer, for example a type of respite service where there is an identified area of concern regarding strain in the older person/carer relationship and a goal to relieve stress on the carer.

Assessors should provide information to carers regarding specific support services that are available for carers to access in their own right and inform carers how to link with these support services such as Carer Gateway, the National Dementia Helpline and other carer-focused dementia supports delivered by Dementia Australia, Dementia Support Australia and consumer support and advocacy. Assessors can directly refer carers (with their consent) to Carer Gateway and the National Dementia Helpline through the Assessor Portal and Aged Care Assessor App.

Carer Gateway website.

Department of Health, Disability and Ageing website: Our work related to dementia | Australian Government Department of Health, Disability and Ageing

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

Dementia Australia website.

Dementia Support Australia website.

12.11.2. People living with mental health conditions

When assessing the aged care needs of older people living with a mental health condition assessors are encouraged to liaise with mental health services to assist their understanding of the older person's needs. Assessors can also assist by facilitating links between the older person, providers, and appropriate mental health services.

Aged care services usually do not have the capacity to adequately meet the needs of people with a serious, uncontrolled mental health condition without the support of, and treatment by, mental health services.

Assessment and approval for entry to aged care is only appropriate if the intensity, type, and model of care is the most appropriate to meet the person's care needs. This includes the following considerations:

- The person's mental health is stable. If they have recently received treatment, their mental health should be stable prior to being assessed although it is understood they may still have significant symptoms.

- Community mental health services will continue to provide collaborative care for those elderly people who have significant or unstable psychiatric symptoms.

The assessor must, prior to commencing an assessment, obtain informed consent for the assessment either from the person (if they have the capacity to do so), or an appointed decision maker consistent with state or territory arrangements who is able to make decisions regarding health, accommodation, and daily living care.

Involuntary mental health care is governed by separate mental health legislation in each state and territory. People who are placed under some form of an involuntary order (e.g., to manage their medicines when living in the community) may be eligible for aged care services. Assessors should consider each referral on a case-by-case basis.

In some jurisdictions, under certain circumstances, mental health legislation empowers the treating psychiatrist to make accommodation decisions in the best interests of a person receiving treatment under an involuntary order. This power is only exercised when a particular accommodation setting is required to facilitate the treatment of a person's mental health condition. It does not replace the need for guardianship when a mental health condition is incidental to that person's need for placement in residential care.

A comprehensive assessment is also required to access residential aged care facilities in jurisdictions where residential aged care facilities are part of the aged mental health service system.

All assessment organisations should develop assessment protocols that reflect relevant state or territory legislation and regulations, to ensure that older people living with a mental health condition are directed to the responsible agency to assess and recommend services most appropriate to meet their care and support needs.

12.11.3. People with palliative care needs

Under the Statement of Rights in section 23 of the Aged Care Act 2024 (the Act), an individual has a right to equitable access to palliative care and end-of-life care when required. The strengthened Aged Care Quality Standards also include outcome 5.7 Palliative Care and End-of-Life Care, that provides the intent for providers to follow, including recognising and addressing the needs, goals and preferences of individuals for palliative care and end-of-life care

Palliative care is person and family-centred treatment, care and support for people living with a life-limiting illness. Palliative care aims to improve quality of life and support people to live well for as long as possible.

The Aged Care Quality and Safety Commission stipulate that care recipients are entitled to receive personal and/or clinical care that is appropriate and recognises their needs, goals, and preferences. This is particularly important for care recipients nearing the end of their lives whose preference may be to remain in their home for as long as possible.

Older people with a life-limiting condition can be supported by multiple care systems including, aged care services, mainstream health care services (including specialist care) and state and territory specialist palliative care services.

Where the aged care system is identified as part of the care requirements for a person over the age of 65 years (or over 50 years for Aboriginal and Torres Strait Islander people and people who are homeless or at risk of homelessness) with a life-limiting illness, it is important the aged care assessment is holistic and considers all of the person's needs. An important part of the aged care assessment will be the identification of palliative care and end of life care needs. Timely provision of appropriate care can support people to be cared for in their home for as long as possible if this is their preference. This is therefore important to consider as part of the assessment and when recommending care options and services.

Assessors should pay particular attention and use their professional judgement to note if an older person has a life limiting illness, they would likely benefit from receiving a palliative approach to care.

Supporting information

Palliative care seeks to prevent and relieve suffering through early identification and correct assessment and treatment of pain and other symptoms, associated with a life-limiting illness, whether physical, psychosocial, or spiritual. The types of supports that may be needed by an individual, their families and carers will vary and may include a range of clinical and non-clinical supports.

Palliative care can occur in almost all settings where health and aged care is provided. It may be provided by a variety of professionals, including specialists, general practitioners, nurses, allied health workers, aged care workers, counsellors, and pastoral carers. The assistance of specialist palliative medicine physicians and nurses may be required when a person's symptoms are complex or difficult to manage.

Palliative care is different to 'end-of-life care'. While palliative care may be provided from the point of diagnosis of a life-limiting illness, end-of-life care is care for a person who is in the last months or weeks of life, including for those whose death is imminent (within weeks or days). The needs of patients are higher at this time and timely access to services is vital. Timely access to aged care services may depend on the services being sought and whether a person is already engaged with an aged care program.

It is therefore important to explore all options for an older person, including whether the Support at Home End-of-Life pathway is appropriate. Eligibility for the End-of-Life Pathway can be found in Chapter 6.

The provision of both palliative care and end-of-life care cuts across systems – care offered through the aged care system should be integrated to facilitate seamless transition, building upon clinical palliative care services offered by primary care professionals, or state-based specialist palliative care services.

For example, where a state or territory provides clinical palliative care services in the home, older people receiving palliative care may also require assistance with basic daily living support and supportive care to ensure they are able to remain at home for as long as

possible. These care needs range from assistance with daily chores to personal care, providing meals, transport assistance, respite care, home modifications and social support.

Department of Health, Disability and Ageing website:

AN-ACC Class 1 – admit for palliative care

National Palliative Care Strategy

Training and tools for health and aged care professionals

The Australian Government funds accredited education and training on palliative care for the workforce.

The Palliative Aged Care Outcomes Program (PACOP) aims to systematically improve palliative and end-of-life care outcomes in aged care settings in Australia.

End of Life Directions for Aged Care (ELDAC) provides information, guidance, and resources for all aged care staff to support palliative care and advance care planning.

Information can be found at **health.gov.au/palliative-care-education**

12.11.4. Older people who are in prison

Usually, aged care assessments will be conducted when the person is released from prison into the community by referral through My Aged Care. Assessments of ex-prisoners in a community setting will depend on the person's needs and the screening and triage outcome. However, in a prison setting, only clinical assessors can undertake such assessments. A triage delegate can only arrange an assessment by a non-clinical assessor to take place after the person is released.

If it is imperative that an assessment occurs in prison, the clinical assessor can conduct an in-prison assessment, provided the prisoner has a release date and the prison is agreeable to the arrangement. By exception, an older person may be assessed in a prison setting by a clinical assessor prior to them securing a release date. This can only occur in cases where a release date is dependent on a needs assessment being undertaken.

In recognition that prisoners can have very complex health and care needs, it is appropriate for a clinical assessor to be supported by another assessor. This is a decision for the assessment organisation to make keeping in mind the health and safety of its assessors. For additional considerations for WHS screen prior to assessment see Chapter 5.

Regardless of whether the assessment occurs in a community or prison setting, Commonwealth subsidised aged care services can only commence after the prisoner is released. It is the responsibility of the relevant state or territory government to provide the appropriate care and services while the person is incarcerated. If the older person is found eligible for Support at Home, the assessor should update the older person's status to 'not

seeking services' at the time of assessment. Upon receiving a prison release date, the older person or registered supporter or other person who support the older person will need to contact My Aged Care to indicate they are actively seeking care to be placed on the Support at Home priority system.

If the person shares (or the assessor is in receipt of) sensitive information, with the older person's consent this can be recorded by adding a sensitive note and/or a sensitive attachment. Providers will be presented with a banner message on My Aged Care where a sensitive note exists prompting them to contact the assessor. The assessor should disclose information where it is applicable to the provider in their provision of care or services to the older person (see Recording sensitive information in Chapter 5). Where it is recorded the older person has challenging behaviours that may impact the safety and welfare of the older person or staff, the assessor should contact the provider to help ensure they can appropriately manage these behaviours once services commence.

The Support Considerations section of the IAT gives assessors the opportunity to ask the older person if there is any further information providers should be aware of in the delivery of care and services. This will allow (although this is up to the older person to agree to) the older person to advise of parole conditions or any implications of their incarceration that relate to effective and safe aged care provision that have not previously been raised during the assessment. The assessor can record this information as a sensitive note and/or sensitive attachment and should add a note in the Support Considerations section of the IAT (and only if appropriate, the Support Plan) indicating that there is a sensitive note and/or sensitive attachment to view.

Assessors should be mindful that there is an increased likelihood that prisoners or ex-prisoners are at risk of vulnerability and complexity and requiring additional linking support (see Delivering Linking Support / Care Coordination to Vulnerable Older people in Chapter 5).

13. Chapter 13: Operating procedures

What you'll find in this chapter

This chapter includes information on privacy, information management and relevant legislation. Also included in this chapter is information about:

- Applying to be delegate
- Information management
- Clinical governance
- Branding
- Resources for consumers
- Reporting and performance

13.1. Applying to be a delegate

Delegate applications are submitted online within the My Aged Care assessor portal.

13.1.1. Delegate on/off form

To become a delegate position, such as a Triage Delegate or Clinical Assessment Delegate and gain the authority to make approval decisions, individuals must complete an application process and be approved by the Department of Health, Disability and Aged Care (the Department). This application is submitted through the My Aged Care assessor portal.

Within the portal, the Delegate on/off form can be used to:

- **Add** users to delegate positions.
- **Cease** existing delegates from delegate positions.
- **Replace** existing delegates noting that the replace functionality will cease existing delegate access and add their replacement in a single step.

A number of rules apply:

- Only assessors, Team Leaders, and delegates can hold delegate positions.
- To apply on behalf of someone else, the applicant must be either a Team Leader or an Assessment Organisation Operational Manager.
- Team Leaders can submit applications for themselves as well as for others.
- Assessment Organisation Operational Managers can only hold a delegate position if they are also an assessor or a Team Leader.

Note: There is no requirement to use the Delegate on/off form to become a non-clinical Delegate until 1 July 2026 when system functionality is turned on. All non-clinical assessors will have a blanket delegation under the Instrument of Delegation to approve CHSP, CHSP AT, CHSP HM. In practice, even though there is a blanket delegation assessment organisations can instruct their workforce to get someone else to approve a client's home support assessment.

All approved delegates are assigned a unique Delegate ID in the My Aged Care system. This ID consists of a 6-character code, where:

- The first three characters represent the assessment organisation ID
- The fourth character indicates the profession ID
- The final two characters identify the specific position within the organisation.

Delegate ID Position setup

The Delegate Position framework derives the position name (Delegate ID Position) for all delegate roles as the concatenation of: 'Initials of delegate role + delegate team ID + profession code + position number'

Initials of delegate role

Table 57. Initials of Delegate Roles

Delegate Role	Initials of Delegate Role
Triage Delegate	TD
Clinical Assessment Delegate	blank (no value)
Non-Clinical Assessment Delegate	NCAD

Delegate team ID

The delegate team ID is an existing field and is unique to an outlet.

Profession code

Table 58. Profession codes

Profession	Profession Code
Non-Clinical	0
Medical Practitioner	1
Registered Nurse	2
Social Worker	3
Occupational Therapist	4
Physiotherapist	5
Other Health Professional	6
Psychologist	7

Position number

The position number is a counter, automatically incremented.

Example:

A Triage Delegate role for an outlet with:

- Delegate Team ID: "7YC"
- Profession: Social Worker (Profession Code: "3")
- Position Number: "00"

The Delegate Position ID will be TD7YC300.

A Clinical Assessment Delegate position (ID: 6SR315) is located in Southern Tasmania (Aged Care Planning Region) for the Tasmanian Department of Health. This role:

- Can only be occupied by a Social Worker
- Is identified by the Position Number: 15 in that outlet.

Using the My Aged Care assessor portal

The My Aged Care assessor portal allows applicants to manage delegate positions through a structured process.

The delegate application process consists of four main steps:

- Create the application – The applicant initiates and submits the application.
- Verify the application – A verifier, who must hold the Team Leader role in the portal, reviews and confirms the application details.
- Support the application – A supporter, who must hold the Assessment Organisation Operational Manager role in the portal, provides the final approval or endorsement.
- Approve the application – The Department reviews the application and any supporting evidence before deciding to approve or deny it.

Each step in the application process must be completed in order, following the system's established rules and workflows.

Portal processes

A key requirement is that applications progress one step at a time. For instance, if a Team Leader submits an application on behalf of another user, they must first create and submit the application. Only after submission can they return to verify it. This structured approach ensures clarity and organisation throughout the process.

Applicants, verifiers, and supporters have access to the proposed delegate's profile details, including their name, contact information, clinical status, occupation, and qualifications. However, these details cannot be updated during the application process. If any information needs to be changed, the applicant must work with the outlet or organisation administrator to update the details within the portal, separately from the application process.

Access to applications is limited to authorised users

Outlet-level Team Leaders and Outlet Administrators have limited access. For applications involving multiple outlets, only Team Leaders overseeing all included outlets can view them. Outlet Administrators have similar restrictions and, like Organisational Administrators, do not participate in processing delegate applications.

Creating a delegate application

When creating a delegate application, delegate positions can be managed by adding, replacing, or ceasing delegates.

- The **Add** option allows the user to create a new delegate position.
- The **Replace** option lets the user cease an existing delegate and assign their replacement.
- The **Cease** option is used to remove a delegate from their positions without assigning a replacement.

Each application must focus on a single delegate role, which must be selected at the time of submission. The available roles are Triage Delegate, Clinical Assessment Delegate, or Non-Clinical Assessment Delegate.

If someone is required to hold multiple roles, separate applications must be submitted for each role. In replace applications, the new delegate automatically inherits the same role as the ceasing delegate.

Important to note

- For Add and Replace applications, selecting the delegate's profession is a key step. The system uses this information to either assign an existing vacant position for that profession or create a new position if no vacancy exists. For Cease applications, there is no need to select a profession. Simply choose one or more positions the delegate currently holds to proceed with their cessation, regardless of their profession.
- Applicants can include start and end dates in their applications. The Date From field specifies when the delegate will begin their role, while the Date To field is used to automate the delegate's dissociation when their term ends. However, the Date To field is not needed for ceasing a delegate, as both temporary and permanent cessations are treated the same by the system.
- As part of the process, applicants must nominate a Team Leader to verify the application and an Assessment Organisation Operational Manager to support it. The system filters the list of eligible Team Leaders to include only those who cover all outlets involved in the application. If no suitable Team Leader is available, the system will display an error message. The Operational Manager must also be selected from the provided list to ensure their role matches the application's requirements.
- Special rules apply when a Team Leader submits their own application. In such cases, they must nominate another Team Leader to verify it. Once submitted, the nominated verifier will handle the next steps.

- The system automatically checks several details during the application process, including the proposed delegate's clinical status, occupation, qualifications, and training. If the delegate does not meet the criteria, warning messages will guide the applicant to update the delegate's user profile or adjust their position type or profession. Applicants can still proceed by acknowledging these issues, and this acknowledgment will be visible to the verifier and supporter in the next stages. Some issues, however, are considered hard stops. For example, if the delegate lacks a clinical status or is assigned a role incompatible with their profile, the application cannot proceed until their user profile is updated.

Note:

The department's My Aged Care Capability Section verifies each application to ensure all required training has been completed.

For details on mandatory training requirements for each position, please refer to the My Aged Care Workforce Learning Strategy.

- Supporting documentation to be uploaded with the application could include MAC learning training transcripts, qualifications, AHPRA registration evidence etc.
- Once the application has been submitted, a confirmation banner will appear confirming that the application has been created and submitted to the verifier for action.

My Aged Care Workforce Learning Strategy.

Assessor Portal User Guide 12 – Managing Delegate Roles

13.2. Information management

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13.2.1. Privacy and Protected Information under the Aged Care Act 2024 (Cth)

Sections 537 to 541 of the *Aged Care Act 2024* (the Act) specifies the purposes for which information can be used or disclosed in accordance with the Act. The collection of information from an older person, their registered supporter(s) and/or appointed decision maker/s for the purposes of determining an individual's eligibility and assessing their access to funded aged care services is authorised by the Act.

Personal information collected during the assessment process is considered protected information. Protected information is defined under section 21 of the Act, as personal information or information, including commercially sensitive information, where the disclosure of which could reasonably be expected to found an action by an entity (other than the Commonwealth) for breach of a duty of confidence. Personal information has the same meaning as in the Privacy Act 1988 (Privacy Act) and is defined as information or an opinion about an identified individual, or an individual who is reasonably identifiable:

- Whether the information is true or not; and

- Whether the information or opinion is recorded in a material form or not.

Sensitive information (within the meaning of the Privacy Act may be personal information. Information is not personal information if it is only about a person who has died.

Additionally, information collected during the assessment process may also be considered sensitive information as defined by section 6 of the Privacy Act which includes information about an individual's identity and health. Sensitive information is afforded additional protection under the Australian Privacy Principles (APP) and should only be used for authorised purposes (see information below about assessment organisations who may be APP entities.

The Aged Care Act 2024 (the Act) imposes strict rules on the management of protected information, stating that a person commits an offence if they make a record of, disclose, or otherwise use protected information that was acquired in the course of performing duties or exercising powers or functions under the Act or the *Aged Care (Transitional Provisions) Act 2024,* where the use or disclosure is not authorised under Division 2 of Part 2 of Chapter 7 of the Act. The maximum penalty for such an offence is imprisonment for up to two years or a fine of 120 penalty units, or both.

To comply with these requirements, individuals and entities who handle assessment information must implement stringent confidentiality measures. This includes secure handling, recording, and storage practices to ensure that the information is safeguarded against unauthorised access or disclosure.

To ensure the proper handling and disclosure of protected information in accordance with the law, assessment organisation staff must follow their organisation's standard operating procedures and guidance in this manual.

Assessment organisations who are APP entities under the Privacy Act will also need to comply with the requirements of the Privacy Act in handling personal information. Where personal information is used or disclosed in accordance with an authorisation in Division 2, Part 2, Chapter 7 of the *Aged Care Act 2024* this will be permitted under the *Privacy Act* (see APP 6.2(b)).

Assessment organisations should consult the Privacy Act and APP Guidelines for further information on the definition of APP entities and its applicability to their organisation.

13.2.2. Collection and protection of information

The collection of information about an older person and their support network as part of the assessment process must comply with the legislative requirements under the Aged Care Act 2024 and Privacy Act 1988 (the Privacy Act). Where applicable assessors must seek and gain informed consent using the My Aged Care Assessment Consent Form (the Consent Form) including reading the consent scripts to the older person or their appointed decision maker (whether or not they are a registered supporter).

Any information collected for the purpose of determining an individual's eligibility and need for Commonwealth-subsidised aged care is collected on behalf of the Commonwealth and is therefore Commonwealth property. This includes any notes, documents or other materials created for the purpose of preparing an older person's record.

The Privacy Act contains further provisions to protect information which applies to assessment organisations.

Where the Privacy Act applies, it is critical that assessment organisations have systems, protocols and processes in place to ensure the safety of older people's records from loss, interference, misuse, unauthorised access, modification or disclosure. This requirement relates to Australian Privacy Principle 11. Penalties may apply to agencies and individuals for breaches of the Privacy Act. Assessment organisations may refer to the Office of the Australian Information Commission for further information on the handling of personal information and the consequences of misuse.

If a record of an assessment is a state or territory government as well as being a Commonwealth record, there may be further requirements to retain and store information under state or territory legislation. Assessment organisations should seek advice from their state or territory government on any state or territory requirements. Assessment organisations must meet all requirements at both levels of government.

All assessment organisation staff should exercise caution and care when handling personal information. If an assessment organisation staff member becomes aware of a potential privacy breach they must discuss this with their assessment organisation manager and follow their organisation's procedures.

13.2.3. Use, storage and retention of information

Records are now created, stored and managed electronically in the My Aged Care portal. In some circumstances, it may be necessary for records to be created in a hard copy paper format (e.g., the Emergency Residential Care - Application for Care form). In these cases, the paper records are to be uploaded to the My Aged Care portal as soon as possible and the paper copy destroyed in accordance with the destruction guidelines (see Destruction below).

Should you require information about the management of legacy records, those records that were created prior to the My Aged Care Gateway please contact your assessment organisation manager who can liaise with the department if necessary for further advice.

13.2.4. Destruction of information

The destruction of new paper records should be undertaken as soon as the record has been captured digitally in the My Aged Care portal, and a true electronic copy has been confirmed. Destruction can be undertaken using class B paper shredders that shred to P-5 security level. Level P-5 provides more security with cross-cut shreds that are only ≤ 30 mm² particles with width ≤ 2 mm.

Alternatively, destruction can also be through a Protective Security Policy Framework endorsed T4 accredited waste management agency.

The destruction of electronic records requires the deletion of all copies of the record from any system in such a way that it is impossible to restore the record. For records that are destroyed and not uploaded to My Aged Care, assessment organisations must also maintain evidence of identifying what has been destroyed and the means of destruction.

Department of Home Affairs website: Protective Security Policy Framework

13.2.5. Use and disclosure of information

Assessors and other staff must be aware that information they acquire or generate in the course of performing their delegated functions or powers under the Aged Care Act 2024 (the Act) may not be recorded or disclosed or otherwise used unless it is in accordance with the Act. Generally, information can be used or disclosed by assessors and staff in the course of performing their delegated powers or functions under the Act or with the consent of the older person. Written records of 'interesting cases' may not be kept by staff members, and cases may not be referenced in public discussion such as in a Letter to the Editor or in social media. There are explicit authorisations for the use and disclosure of information under the Act. These may generally be categorised as:

- **general authorisations**- including but not limited to functions and powers under the Act, for proceedings, with consent, preventing serious threat to safety, health or wellbeing, for the purposes of worker screening
- **entrusted persons** – disclosure to a minister, disclosure for the purposes of obtaining legal advice or another legal service, for the provision of services to an individual (but only for specific purposes, such as assessing the level of care an individual needs, relative to the needs of others)
- **authorisation by the System Governor or Appointed Commissioner** – disclosure to relevant Commonwealth bodies and agencies, disclosure to a registered supporter of an individual accessing or seeking access to funded aged care, disclosure for continuation of funded aged care services, disclosure for research, disclosure for law enforcement and revenue protection, disclosure for maintenance of professional standards, disclosure for certified purposes
- **authorisation by the System Governor or Appointed Commissioner for certain inquiries**- disclosure to the coroner, disclosure for state or territory complaints
- **Authorisation by the System Governor for grants and quality purposes**- disclosure for grants and disclosure for star ratings

Disclosures made under any of the authorisations must be in accordance with the specific requirements outlined under Division 2 of Part 2 of Chapter 7 of the Aged Care Act 2024 (the Act).

Any systems developed for the collection and analysis of data should incorporate adequate procedures to protect the privacy of people being assessed. If data is to be used for purposes other than assessment, or individual care planning, assessors must have procedures in place to ensure that older person confidentiality is maintained and individuals cannot be identified.

Older people and their registered supporters should be encouraged to access their My Aged Care online account. This gives direct access to the older person's assessment information, which they can disclose to other parties as they wish.

In cases where there is no consent to release information or any doubt about the release of information, the assessor should discuss this situation with the organisation's manager. The manager may further consult the assessment organisation's auspice organisation, the state or territory government, the department or obtain independent legal advice if any doubt remains, before releasing information.

Australian Security Intelligence Organisation website: ASIO T4 Protective Security

Federal Register of Legislation website: Aged Care Act 2024 - Federal Register of Legislation

Archives Act 1983

Electronic Transaction Act 1999 (see Part2, Division 2, Section 12 – Retention)

Privacy Act 1988 - Federal Register of Legislation

National Archives of Australia website: Records Authority 2011/00396196 Department of Health and Ageing (includes Aged Care)

Office of the Australian Information Commissioner website:

Australian Privacy Principles

13.2.6. Freedom of information

The Commonwealth *Freedom of Information Act 1982* (Freedom of Information Act) gives members of the public the right to request access to government-held information. This includes information the government holds about individuals or about government policies and decisions. The Freedom of Information Act extends, as far as possible, the right of the Australian community to access information (generally documents) in the possession of the Commonwealth, limited only by considerations of the protection of essential public interest and of the private and business affairs of persons in respect of whom information is collected and held by departments and public authorities.

Federal Register of Legislation website: Freedom of Information Act 1982

Office of the Australian Information Commissioner: What is freedom of information? | OAIC

13.2.7. Framework for Governance of Indigenous Data

The Framework for Governance of Indigenous Data provides a stepping stone towards greater awareness and acceptance by Australian Government agencies of the principles of Indigenous Data Sovereignty.

The Indigenous Data Sovereignty Principles are outlined by the Maiam nayri Wingara Indigenous Data Sovereignty Collective. The principles concern the right of Aboriginal and Torres Strait Islander people to exercise ownership and control over Indigenous data at all phases of the data lifecycle. Indigenous data is defined by Maiam nayri Wingara as 'information or knowledge, in any format or medium, which is about and may affect Indigenous peoples both collectively and individually.'

The framework contains the following guidelines for Australian Government agencies to change data governance practices, in alignment with the commitments made in the National Agreement on Closing the Gap:

- **Partner with Aboriginal and Torres Strait Islander people-** establishing formal partnerships and shared decision-making with Aboriginal and Torres Strait Islander people, embedding Indigenous leadership into data governance.

- **Build data-related capabilities-** Supplementing of technical skills with understanding of the ways in which Indigenous data has been collected and the narratives and challenges which arise from current datasets. Supporting Aboriginal and Torres Strait Islander communities and organisations through training and up-skilling Indigenous people.

- **Provide knowledge of data assets-** Supporting Aboriginal and Torres Strait Islander people to locate and access relevant government held data by informing Indigenous people about what data is held by the government, its usage and access permissions.

- **Build an inclusive data system-** The structural transformation of datasets to support the inclusion of Aboriginal and Torres Strait Islander people in data governance.

https://www.oaic.gov.au/privacy/the-privacy-act/Framework for Governance of Indigenous Data

13.3. Clinical governance

Assessment organisations have a responsibility to implement effective clinical governance, made operational through a clinical governance framework. A clinical governance framework is a framework that describes an organisation's approach to clinical governance. It must include the practical, clinical supports that are in place for staff who may need to exercise clinical judgement or undertake elements of an aged care needs assessment that are clinical in nature.

Appendix D provides guidance on how to implement effective clinical governance.

13.4. Separation of assessment services and delivery of aged care services

An assessment organisation delivers the assessment of older person needs independent of provider preferences, and ensures older people are referred only to the services that will fulfil their needs and goals.

It is a requirement for assessment organisations to contractually have operational separation of assessment services from service delivery (where applicable) for all contracted assessment organisations and any relevant sub-contractors (including consortiums).

Assessment organisations that deliver both assessment services and service delivery must ensure there is a clear separation of service, particularly in the facilitation and management of assessments and referrals to aged care services. Assessment organisations must have policies and procedures in place to assure the separation of assessment from service delivery**.**

Assessment organisations must seek prior approval from the Department of Health, Disability and Ageing (the department) before engaging or using assessment organisations and any relevant sub-contractors to provide aged care services.

13.5. Branding

Assessment organisations that are contracted to (or in an agreement with) the Australian Government (under the oversight of the department) are required to comply with branding guidance that is included in the following style guides:

- Ensure all materials produced adhere to the Australian Government Branding Guidelines.
- Ensure all web-based content complies with the relevant Digital Service Standards including Requirements for Australian Government websites and comply with the Web Content Accessibility Guidelines (WCAG) version 2.2 AA for all government websites.

Subcontractors are required to consult with their primary contractor on branding requests.

- **Department of Prime Minister and Cabinet website:** Australian Government Branding Guidelines | PM&C
- Digital Service Standards Web Content Accessibility Guidelines (WCAG) 2.2

13.6. Aged care resources for older people

Hard copies of My Aged Care resources including booklets, brochures, posters and magnets are available from National Mailing and Marketing by emailing: health@nationalmailing.com.au or calling (02) 6269 1025.

Information and resources about aged care can be found on the My Aged Care website. Recommended information and resources include:

- *Exploring aged care* booklet for older people, their families and carers:
- Signing up to receive the EngAged, our monthly newsletter on aged care and ageing well:
- Following the Council of Elders on Facebook and keep up with the work they are doing. Find out what the Department of Health, Disability and Ageing is doing to help people in Australia age well:

Resources | My Aged Care

Exploring aged care booklet

EngAged newsletter: health.gov.au/aged-care-newsletter-subscribe

facebook.com/groups/AgedCareCouncilOfElders

health.gov.au/topics/positive-ageing-is-ageing-well

13.7. Reporting and performance

Assessment organisations are expected to meet measures on timeliness and performance according to their contractual agreements with the Australian Government.

The department makes available various business intelligence (BI) and management reports which support assessment organisations in monitoring and managing their performance against agreed KPIs and other measures. These reports will progressively become available during the establishment of the Single Assessment System workforce. Assessment Organisations can access Qlik reports on the Health Data Portal, reports currently available include:

- SAW001: Referral and Assessment Volumes
- SAW 002: Timeliness
- SAW003: Outstanding Assessments
- SAW005: Organisation Performance
- SAW006: Recommended Services
- SAW007: Service Referrals
- SAW008: Home Care Package Approvals
- SAW 009: Referral Data Breakdown
- SAW010: Assessment Data Breakdown

As further reports become available, they will be communicated to Assessment Organisations and listed above. For queries regarding the Single Assessment System Qlik reports, support documentation or assistance with access to the Health Data Portal, please contact AgedCare.Assessment.Reporting@health.gov.au

14. Chapter 14 – Fees and payments

What you'll find in this chapter:

This chapter provides guidance on:

- fees,
- payments, and
- participant contributions for funded aged care services.

All sections in this chapter are new content.

14.1. An assessor's role in advising clients about fees and payments

It is important that older people understand the potential costs of care early in their interaction with the aged care system.

Assessors are not responsible for providing detailed financial information about the fees or charges that an older person may be charged to access aged care services, but they do have a role in advising older people about where they can access the information they need and what the process may entail. They should be able to assist clients to access appropriate support should an older person be experiencing financial disadvantage (see section 14.2.4Financial Hardship).

Ideally, clients should be referred to the My Aged Care website and the contact centre for information regarding care costs and fees prior to the face-to-face assessment. This gives the client time to consider the information prior to the assessment.

Note:

After the assessment, rather than the assessor handing out Services Australia hard copy forms to the client (which may lead the client to complete a form unnecessarily), assessors can leave booklets specific to their service recommendations which contain necessary fee information for that program or type of care.

Assessors may wish to point out the section of the booklet which provides information about fees, who to contact about whether they need to complete a form and how to access the forms if required (see Chapter 13).

14.2. Aged care program fees

14.2.1. Fees for Commonwealth Home Support Program (CHSP)

A provider delivering funded aged care services through a service group under the CHSP may charge an individual an amount for or in connection with those services (the CHSP contribution), in accordance with section 286 of the Aged Care Act 2024. Providers must have a publicly available financial hardship policy that covers how clients can apply for a waiver or reduction of the CHSP contribution.

The CHSP contribution must be agreed with the client in writing, including how and when it is to be paid and outlined in the client's Service Agreement. In agreeing to the amount of CHSP contribution, providers should consider a range of factors including:

- business costs associated with delivering the service
- affordability for CHSP clients
- the socioeconomic circumstances of those receiving services.

There is no formal means testing for CHSP client contributions. The client contribution fee may vary from person to person. This is because the fee can vary depending on the specific services a client receives and their individual capacity to pay. Two clients of a similar age with similar support needs may pay different CHSP contributions for a similar service.

The National CHSP Client Contribution Framework outlines the principles that service providers can adopt in setting their client contribution policies with a view to ensuring that those who can afford to contribute to the cost of their care do so whilst protecting those most vulnerable.

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

Commonwealth Home Support Program (CHSP) resources

14.2.2. Fees for Support at Home participants

The introduction of contributions in the Support at Home Program have replaced existing fee arrangements under the Home Care Package Program.

With the transition from the Home Care Package program to Support at Home, changes have been made to how participant contributions are calculated. This information is applicable for older people accessing services under the Support at Home Program, including through the Restorative Care Pathway, End-of-Life Pathway and Assistive Technology and Home Modifications (AT-HM) scheme.

For Support at Home participants, an income and assets assessment by Services Australia determines participant contributions. Contributions will be different for each participant

based on the type of service received, the outcome of their income and assets assessment and their pension status.

- Clinical support services will attract no contribution fees as they are fully funded by the government for all participants.
- Independence services such as personal care will attract moderate contributions.
- Everyday living services such as cleaning and gardening will attract the highest contributions.

For full or part pensioners, Services Australia will use the information on a person's income and assets assessment that has been provide for their pension assessment to determine their Support at Home contributions. Non-pensioners, once approved for Support at Home will need to complete an income and assets assessment if Services Australia does not already have their financial details.

Completing an income and assets assessment is not mandatory, however, Support at Home participants who choose not to complete one can be asked to pay the maximum participant contribution rate.

Providers do not need to wait for an income assessment to be completed before an older person commences Support at Home services. Service providers and participants can agree on a temporary contribution rate while a new participant's income and assets are being assessed by Services Australia. The Support at Home fee estimator, available on the department's website can be used to assist in determining these temporary rates.

A no worse off principle applies for grandfathered Home Care Package care recipients who, on or before 12 September 2024, were either receiving a Home Care Package, on the National Priority System or assessed as eligible for a package. The no worse off principle applies to financial contributions. These participants will make the same contributions, or lower, than they were assessed as having to pay under Home Care Package Program arrangements, even if they are reassessed into a higher Support at Home classification at a later date. The same lifetime cap will also be honoured for this cohort (approximately $85,000).

For Support at Home Participants there are defined circumstances when they may simultaneously access CHSP services. When doing so, a Support at Home participant must pay regular CHSP client contribution fees. These client contribution rates are subject to government subsidisation. The Support at Home participant will need to fund the client contribution fees themselves and cannot use their Support at Home funding allocation. This arrangement is applicable in the following circumstances:

- Pre-existing CHP social support group
- Hoarding and Squalor
- Short-term respite
- Emergency access

For further information about the circumstances when a Support at Home Participant can simultaneously access CHSP services, refer to Chapter 6.

If required, Support at Home Participants can choose to pay for additional CHSP services out of their Support at Home budget. As the Support at Home participant is already receiving government subsidised aged care services, additional CHSP services will be charged at the full cost and not subject to further subsidisation.

Restorative Care Pathway

Participant contributions apply for services delivered in the independence and everyday living categories. Services in the clinical support category do not require participant contributions and are fully funded by the government.

ATHM Scheme

Support at Home participants may be required to make contributions for AT-HM items and services. AT-HM items attract a contribution rate equivalent to the independence category. Prescriptions and wrap-around services fall under the clinical supports category, requiring no participant contribution.

End-of-Life Pathway

Consistent with ongoing Support at Home, participant contribution arrangements apply for independence and everyday living services accessed under the End-of-Life Pathway. For services in the clinical supports category, no participant contribution is required as these services are fully funded by the government.

Further information is available on the Department of Health, Disability and Ageing website:

- Support at Home Participant contributions
- Support at Home Program Manual
- Schedule of Fees and Charges for Residential and Home Care

My Aged Care Website:

- Aged Care Resources
- Fact Sheet: Support at Home program - participant contributions

Services Australia website:

- Providing home care
- Providing residential care

14.2.3. Older people entering permanent residential care

How much a person pays for their residential aged care is based on their income and assets. Services Australia or the Department of Veterans' Affairs (DVA) assesses income and assets, and this is known as an aged care means assessment. If an older person is a member of a couple, they will be assessed on half of their combined income and assets. Residents who have had their means assessed are required to report changes to their financial circumstances to Services Australia or DVA within 28 days to help keep their fees correct.

People who can't afford to make a higher contribution will only pay the basic daily fee. Those who can afford to will contribute more to their aged care costs.

If an older person chooses not to have their means assessed, they will not be eligible for assistance with care and accommodation costs.

If a person moves into an aged care home for permanent residential care, they will pay fees under one of 2 arrangements:

- **1 July 2014 fee arrangements:** these apply for people who were approved for or accessing a Home Care Package on 12 September 2024, and who are therefore protected by the 'no worse off principle" and will pay fees under the 1 July 2014 arrangements.
- **1 November 2025 fee arrangements:** these apply to people who first enter residential care on or after 1 November 2025.

1 July 2014 fee arrangements

Residents under these arrangements will not be affected by the changes to means assessments under the *Aged Care Act 2024*.

Before entering into permanent residential care, an older person should have their means assessed to see if they're eligible for Australian Government assistance with fees and accommodation costs. The fees they pay will depend on the outcome of their means assessment and what they agree on with their aged care provider. Residents can also submit an *Aged care calculation of your cost of care form* after entering aged care.

All fees must be clearly written in the resident or service agreement, accommodation agreement and the optional higher everyday living agreement.

An older person may need to pay some or all of these fees:

- basic daily fee
- means tested care fee
- accommodation costs
- fees for optional services.

Understanding fees for aged care homes – 1 July 2014 fee arrangements | Australian Government Department of Health, Disability and Ageing

Means assessment for residential aged care | Australian Government Department of Health, Disability and Ageing

1 November 2025 fee arrangements

Residents who enter care after 1 November 2025 will be affected by means assessment changes under the Aged Care Act 2024. These include:

- new income and asset limits will determine the new means tested fees
- the hotelling supplement will be means tested rather than paid in full by the government, and some residents will contribute to it with a hotelling contribution
- some residents will pay a new means tested non-clinical care contribution with daily and lifetime caps.

Before entering permanent residential care, an older person should have their means assessed to see if they're eligible for Australian Government assistance with fees and accommodation costs. The fees they pay will depend on the outcome of their means assessment and what they agree on with their aged care provider. Residents can also submit an *Aged care calculation of your cost of care form* after entering aged care.

All fees must be clearly written in the service agreement with the provider, accommodation agreement and the optional higher everyday living agreement. These fees may change over time during the time of an older person's care.

Older people may need to pay some or all of these fees:

- basic daily fee
- hotelling contribution
- non-clinical care contribution
- accommodation costs
- higher everyday living fee.

Understanding fees for aged care homes – 1 November 2025 fee arrangements | Australian Government Department of Health, Disability and Ageing

Means assessment for residential aged care | Australian Government Department of Health, Disability and Ageing

14.2.4. Financial hardship

From 1 November, financial hardship arrangements will continue to be available if an older person can't afford to contribute to the cost of their aged care, both in residential care and in-home care. An older person will be assessed on their specific circumstances. If approved for hardship assistance, the Australian Government will pay some (or all) of their aged care fees. The government will pay any approved amounts to the aged care provider on the older person's behalf. If an older person is required to pay some of their fees, they will continue to pay those to their provider.

To apply for financial hardship assistance, an older person must meet certain requirements and complete the Aged Care Claim for Financial Hardship Assistance form. This form is sent to Services Australia to assess the application and they will let the older person know in writing of their decision and what assistance they are eligible for. This form should be submitted by an older person once they start accessing aged care services.

Hardship assistance for aged care – Fact sheet

Financial hardship assistance | My Aged Care

14.2.5. Fees payable by older people receiving transition care

Registered providers may ask individuals to pay a care fee as a contribution to the cost of their care. Any fees must be fully explained to the individual and the amount charged forms part of the service agreement between the individual and registered provider.

The maximum amount that can be charged as per section 286-10 of the *Aged Care Rules 2025* is:

- if Transition Care Program (TCP) is delivered through the residential care service group —the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); or
- if TCP is delivered in a community/home setting and is delivered through the home support, or assistive technology service groups — the amount obtained by rounding down to the nearest cent the amount equal to 17.5% of the basic age pension amount (worked out on a per day basis).

An individual's access to transition care should not be affected by their ability to pay fees but should be decided based on their need for care and the capacity of the registered provider to meet that need. Decisions on whether to charge fees are entirely at the discretion of each State and Territory. The Australian Government recommends that fees be waived for financially disadvantaged individuals. Information on the cost of transition care for individuals is outlined on the My Aged Care website.

Transition care | My Aged Care

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

14.2.6. Non-Australian residents

Non-Australian residents are not excluded from entitlements under the *Aged Care 2024* (the Act) and Visa holders do not require a Medicare Card in order to access an assessment.

Under the Act, non-Australian residents may be eligible for Government assistance with their aged care costs, if the person has been approved by an assessor and has had their income (for home care) or means (for residential care) assessed by Services Australia.

While the Australian Government is the majority funder of aged care, beyond this support it is expected that people will use their income and/or assets, depending on their care type, to contribute to the costs of their care, where they can afford to do so. The amount that the person can be asked to contribute will be assessed by Services Australia under the same rules as any other aged care recipient.

In the event that a non-Australian resident client requests advice from an assessor regarding what fees and payments they may be required to contribute towards their home care or residential care services, they should be advised to complete an income or means assessment to determine their contribution. This applies for all clients who wish to receive Government assistance with the cost of their care, regardless of residency status.

Income and means assessment

:

APPENDIX A – Overview of changes in the assessment process from the commencement of the Aged Care Act 2024

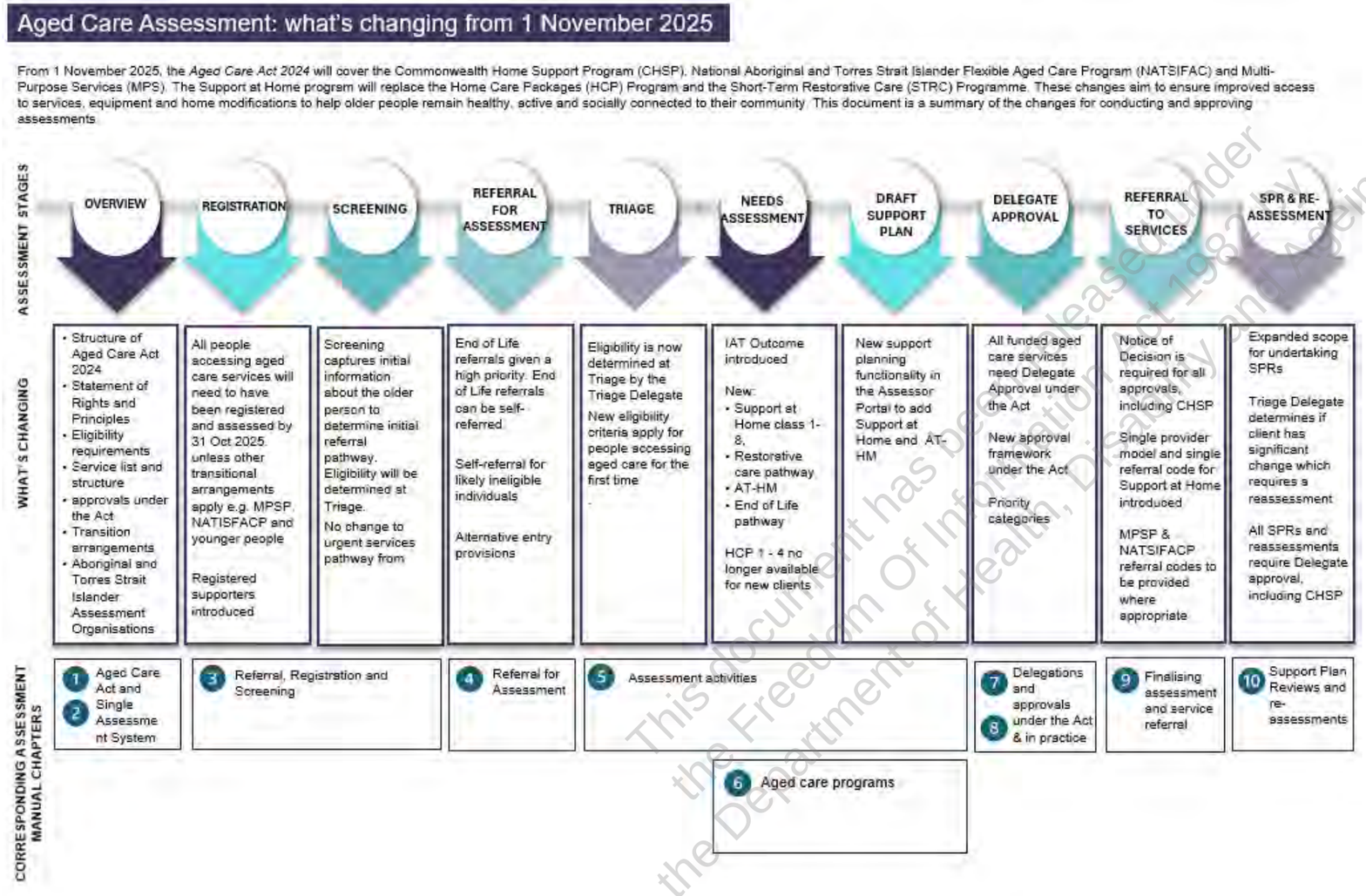

Figure 11 – Overview of changes in the assessment process from commencement of the Aged Care Act 2024

APPENDIX B – Glossary

Table 59. Glossary of terms

Term	Acronym/ abbreviation	Definition
Administrative Review Tribunal	ART	The Administrative Review Tribunal (ART) provides independent merit reviews of a wide range of administrative decisions made by the Australian Government. The ART can review decisions made under Commonwealth and Norfolk Island laws. The ART aim to make their review process accessible, fair, just, economical, informal and quick.
Aboriginal and Torres Strait Islander Aged Care Framework		This Framework establishes a 2035 vision for older Aboriginal and Torres Strait Islander people to age well by having their spiritual, physical and mental health needs met through holistic, high-quality and culturally safe aged care. This care should promote wellbeing, deliver trauma aware and healing informed responses and empower connection to culture, family, community and Country or Island Home.
Aged Care Act 2024 (Cth)	The Act	The *Aged Care Act 2024* (Cth) replaces the *Aged Care Act 1997* (Cth) as the primary piece of aged care legislation from 1 November 2025. In response to the first recommendation of the Royal Commission into Aged Care Quality and Safety, the Act was developed to implement fundamental reforms to aged care. It provides a legislative basis for a rights based aged care system focused on the safety, health and wellbeing of older people. The legislative framework provided by the Act sets out the governance of the aged care system and the requirements to access and deliver funded aged care services. It further introduces a new risk-based regulatory model focused on increasing provider accountability and encouraging the delivery of high quality funded aged care services by registered providers.
Aged Care (Consequential and Transitional		The *Aged Care (Consequential and Transitional Provisions) Act 2024* provides for transitional arrangements to support the commencement of the *Aged Care Act 2024*.

Term	Acronym/ abbreviation	Definition
Provisions) Act 2024		
Aged Care Act 1997 (Cth)		From 1 November 2025, the *Aged Care Act 1997* (Cth) will cease as the primary piece of aged care legislation. It will be superseded by the *Aged Care Act 2024* (Cth). From the cessation of the Act on 1 November 2025, Assessment Organisations should consult the *Aged Care Act 2024* (Cth) for information on access, delivery and governance of the aged care system.
Aged Care Assessment Quality Framework	Framework	Assessment organisations are required to use the Aged Care Assessment Quality Framework to maintain a consistent, high quality assessment experience for every older person.
Aged Care Diversity Framework		The Aged Care Diversity Framework is an overarching set of principles designed to ensure an accessible aged care system where people, regardless of their individual social, cultural, linguistic, religious, spiritual, psychological, medical and care needs are able to access respectful and inclusive aged care services.
Aged care needs assessor		A person who conducts aged care assessments, for home support and comprehensive assessments. An aged care needs assessor can be a clinical assessor or a non-clinical assessor.
Aged Care Principles		From 1 November 2025, the *Aged Care Act 2024* (Cth) will replace existing aged care legislation including the Aged Care Principles. Once commenced, Assessment Organisations should consult the *Aged Care Act 2024* (Cth) for information on access, delivery and governance of the aged care system.
AN-ACC Assessment Tool		Assessment tool used by residential aged care funding assessors to conduct residential aged care funding assessments.

Term	Acronym/ abbreviation	Definition
Assessment organisations	N/A	An entity engaged by the Department to provide Aged Care Needs Assessment Services and/or RAC Funding Assessment Services.
Assessor	N/A	An aged care needs assessor.
Aged Care Specialist Officer	ACSO	ACSO, located in some Services Australia service centers, help people with their aged care matters and provide in-depth support including in relation to financial information and means assessment.
Active, appointed Decision Maker	N/A	'Active, appointed decision maker' is the term used for a person who would be considered a 'guardian etc.' under the *Aged Care Act 2024* (Cth). If a person is a registered supporter and is also an active, appointed decision maker for an older person (for example, the person is also an enduring attorney for the older person they are registered to support), they are recorded as a 'supporter guardian' for Information Communications Technology (ICT) purposes. Active, appointed decision makers can only make decisions for an older person within the scope of their legal authority under a Commonwealth, state or territory arrangement.
Assistive technology	AT	Is any item, piece of equipment or product that is used to help an older person do things more easily or complete activities they can no longer do independently.
Assistive Technology and Home Modifications (AT-HM) list	AT-HM list	A list that sets out the defined equipment, products, and home modifications that can be purchased for eligible participants under the AT-HM scheme.
Assistive Technology and Home Modifications scheme	AT-HM scheme	The scheme providing assistive technology and home modifications funding for eligible participants.

Term	Acronym/ abbreviation	Definition
AT-HM scheme guidelines		The AT-HM scheme guidelines provide additional information and processes in relation to the AT-HM scheme.
AT-HM tier guide		A guide created to support assessors in making an AT-HM funding tier recommendation.
Australian National Aged Care Classification	AN-ACC	Funding model for residential aged care, effective from 1 October 2022.
Australian Privacy Principle/s	APP/s	The Privacy Act includes 13 APPs in Schedule 1 that apply to the handling of personal information by most Australian and Norfolk Island Government agencies and some private sector organisations.
Care finder		Care finders assist vulnerable older Australians who do not have someone who is able to help them access aged care services and other relevant supports in the community. Contact information for care finder services in each region is on the My Aged Care website at Help from a care finder | My Aged Care
Classification		Refers to the classification of a Support at Home participant, including: • Ongoing classification (Classifications 1-8) • Short-term classifications (AT-HM scheme, Restorative Care Pathway Classification and End-of-Life Classification). Also refers to residential care classification (ongoing or short-term)
Clinical aged care needs assessor		A clinically trained assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Commonwealth and in the My Aged Care Workforce Learning Strategy 2024 (or subsequent versions). A clinical assessor undertakes complex (comprehensive)

Term	Acronym/ abbreviation	Definition
		aged care needs assessments with older people and will be required to exercise clinical judgement.
Commonwealth Continuity of Support Programme	CoS	The Continuity of Support Programme has been replaced with Disability Support for Older Australians (DSOA).
Commonwealth Home Support Program	CHSP	The Commonwealth Home Support Program provides a broad range of entry-level support services to assist older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people and people who are homelessness or at risk of homelessness) to live independently in their homes and communities. From 1 November 2025, the CHSP comes under the *Aged Care Act 2024*.
Comprehensive assessment		An assessment type for people with more complex needs. Comprehensive assessments are undertaken by clinical assessors.
Cultural Safety for Aboriginal and Torres Strait Islander people		The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) defined cultural safety as: 'Cultural safety requires understanding one's own culture and the impact that your culture, thinking, and actions may have on the culture and wellbeing of others through ongoing critical self-reflection. Only the care recipient themselves can determine whether the service is culturally safe. Ensuring access to a culturally safe, respectful, responsive and racism free aged care system is inherent for the optimal safety, autonomy, dignity, and absolute wellbeing of Aboriginal and Torres Strait Islander Elders, senior and older people, their families and community. Aged care service providers and workers must take responsibility for building trust and relationships with Aboriginal and Torres Strait Islander service users, and their families, and for creating a new aged care system which centres

Term	Acronym/ abbreviation	Definition
		on their living experience, cultural, and ageing needs, as determined by Aboriginal and Torres Strait Islander service users themselves. The implementation of a trauma aware, healing informed approach to professional practice, and facilitating a greater understanding and respect for individual and collective cultures, histories, knowledges, traditions, stories, and values of Aboriginal and Torres Strait Islander service users, their families and communities, will greatly support the delivery of a quality and culturally safe aged care system. Aged care service providers must also firmly commit to continuously measure and improve structures and behaviours necessary for cultural safety and quality support to remain embedded in the Australian aged care system' According to the Australian Health Practitioner Regulation Agency (AHPRA): "Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities." It involves ongoing critical reflection by health practitioners on their own knowledge, skills, attitudes, and power differentials, and how these affect their practice
Departmental delegate		A departmental employee whose position has been delegated powers and functions under a section of the *Aged Care Act 2024* (Cth) by the System Governor.
Disability Support for Older Australians	DSOA	DSOA provides funding for a range of services including Assistance in Supported Independent Living, Assistance with Self-Care Activities, Specialist/Behavioural Intervention Support, Therapy, and Case Management.
Elder Care Support Program		This workforce helps older Aboriginal and Torres Strait Islander people, their families and carers, to access aged care services across urban, regional and remote Australia to meet their physical and cultural needs.

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

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

Term	Acronym/ abbreviation	Definition
My Health Record	MHR	My Health Record is a secure online summary of key patient health information. Healthcare providers can access the system to view and add information.
National Aboriginal and Torres Strait Islander Flexible Aged Care Program	NATSIFAC	The National Aboriginal and Torres Strait Islander Flexible Aged Care Program funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. These services are mainly located in remote and very remote locations.
National Disability Insurance Scheme/Agency	NDIS or NDIA	The NDIS provides support for people with disability, their families and carers in Australia. The NDIS will provide all Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life. This may include personal care and support, access to the community, therapy services and essential equipment.
Non-clinical aged care needs assessor	Non -clinical assessor	An assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Commonwealth and in the My Aged Care Workforce Learning Strategy 2024 (or subsequent versions). A non-clinical assessor undertakes simple (home support) aged care needs assessments with older people.
Prescribed assistive technology		Assistive technology that would benefit from a prescription from a suitably qualified health professional.
Privacy Act 1988	The Privacy Act	The *Privacy Act 1988* applies to the collection, retention and use of personal information by assessors and regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information and access to and correction of that information.
Progressive condition		A medical condition that worsens over time, resulting in a range of limitations in function which can affect quality of life, daily living and community activities. (The 13 conditions listed

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

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

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

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

APPENDIX C – Contact details

Table 60. Contact details

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

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

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

Guidance purpose

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

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

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

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

Your assessment organisation's clinical governance framework must describe the practical, clinical supports that are in place for staff who may need to exercise clinical judgement or undertake elements of an aged care needs assessment that are clinical in nature.

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

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

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

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

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

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

How to use this guidance

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

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

Elements of a clinical governance framework

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

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

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

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

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

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

Table 61. Roles and responsibilities

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

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

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

Table 62. Role and training requirements

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

Element 3: Provide clinical support to assessors

Table 63. Clinical support to assessors

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

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

Element 4: Monitor assessment quality and drive continuous improvement

Table 64. Monitoring of assessment quality and continuous improvement

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

Element 5: Build relationships to foster innovation and continuous improvement

Table 65. Relationship building to foster innovation and continuous improvement

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

APPENDIX E – Clinical attendance

Questions in the IAT that require clinical attendance

Table 66. IAT questions that require clinical attendance

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

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

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

Older person scenarios — clinical attendance

Meet Clyde

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

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

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

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

Meet Jane

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

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

Meet Alex

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

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

APPENDIX F – Wellness and reablement

Introduction

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

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

What is Wellness and reablement?

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

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

Wellness

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

Reablement

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

Why wellness and reablement is important

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

Understanding the ageing journey – the life curve

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

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

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

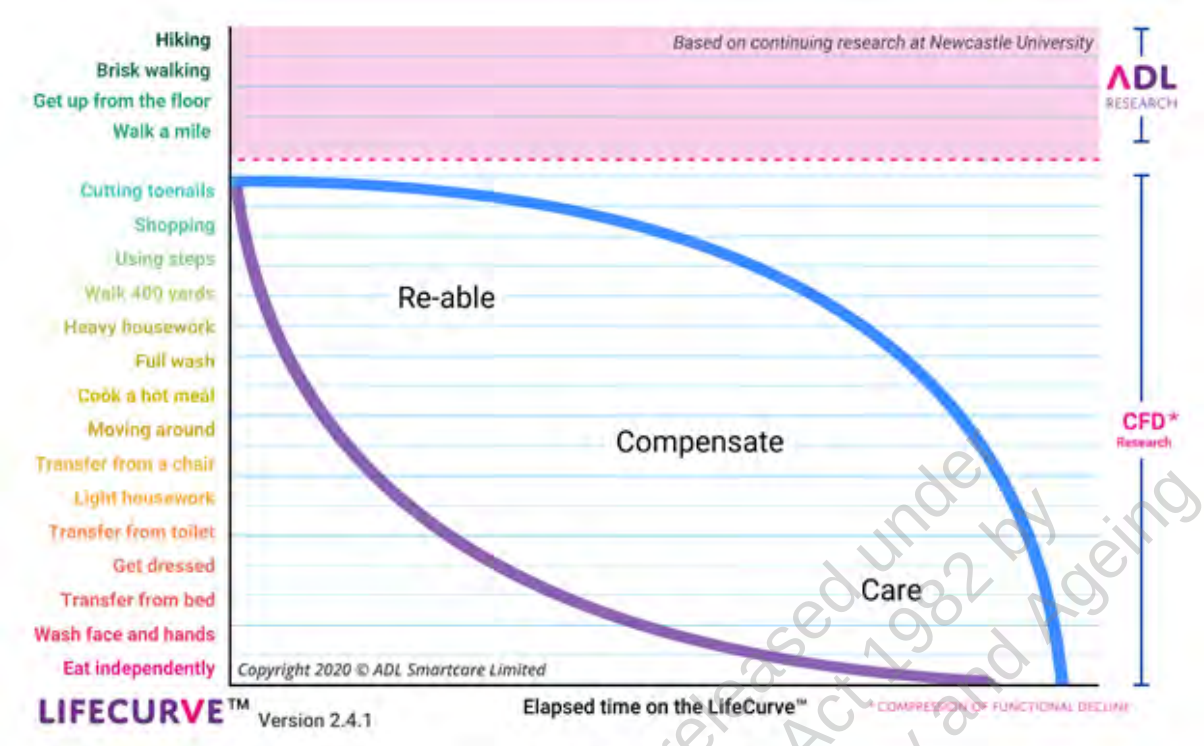

Figure 12 – LifeCurveTM

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

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

Benefits of a wellness and reablement approach

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

Benefits for older people

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

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

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

Benefits for aged care assessment organisations

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

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

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

Benefits for families and carers

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

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

Older person scenarios — Applying a wellness and reablement approach

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

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

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

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

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

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

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

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

Principles of wellness and reablement

Wellness and reablement describe an overall approach to service delivery.

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

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

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

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

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

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

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

Time-limited support

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

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

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

Other time-limited support could include:

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

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

Wellness and reablement obligations and supports

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

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

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

Other resources

Wellness and reablement resources page

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

Older person scenario – Supporting greater independence[7]

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

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

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

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

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

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

Strategies to assist embedding wellness and reablement

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

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

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

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

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

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

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

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

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

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

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

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

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

Assessment and support planning

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX G – Aged care assessment workforce credentials

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

Table 67. Aged care assessment workforce credentials and training requirements

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

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

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

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

*Suitable tertiary qualifications are those that:

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

APPENDIX H – AT-HM terms

Table 68. AT-HM terms and definitions

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

Australian Government
Department of Health, Disability and Ageing

Assessment Organisation Forum

17 November 2025

Below are responses to the questions received during the forum, grouped by theme.

THEME: SUPPORT AT HOME AND CHSP	
Question	**Answer**
If the IAT outcome is CHSP is the older person eligible for residential respite or permanent residential care?	The classification algorithm does not make any calculations nor recommendations for permanent or respite residential aged care approvals. This still relies on the assessor determining eligibility based on the residential aged care guidelines and discussing with the older person their will and preference for these approvals.

s22 [redacted]

s22 [redacted]

THEME: DELEGATES/DELEGATION	
Question	**Answer**
Has the Assessment Delegate role effectively become redundant now that there is no capacity to override an IAT outcome? In relation to the Reconsiderations Team—if IAT outcomes cannot be overridden, will we still be contacted regarding the outcome >> Yes, in the notice of decision it is worded that the delegate has determined they are not eligible - which is not accurate decisions? Just forecasting the likely spike in volume for the Reconsiderations Team.	Assessment Delegates continue to play a crucial role in the assessment process. Delegates remain responsible for reviewing and approving assessments ensuring decisions are legally sound, evidence-based and meet eligibility requirements. When undertaking their role delegates must be satisfied that an older person meets the eligibility criteria for all recommended care types, the IAT Outcome cannot determine this in the place of a delegate. The IAT Outcome determines an older person's eligibility for ongoing home support services under CHSP or SaH and recommends a CHSP or a suitable SaH classification level. Delegates have a more expansive role requiring them to be satisfied that all care types recommended for an older person.

s22 [redacted]

THEME: IAT AND OVERRIDE	
Question	**Answer**
It would be useful to know how and where the algorithm works and triggers so we can seek consistency and equity for all clients.	The IAT Classification Algorithm is a set of rules and takes the responses that an assessor enters into the IAT across the Carer, Medical, Medications, Function, Physical, Personal Health and Frailty, Social Cognition and Psychological domains to understand an older person's clinical characteristics. From these inputs it determines an older person's classification level for ongoing home support services. For a given set of clinical characteristics, the IAT Classification Algorithm will always generate the same classification level.
The IAT does not incorporate consideration of existing CHSP support arrangements, which is resulting in inaccurate funding classifications. Please review the weighting applied within the functional domain, specifically across the categories of Completely Able, Needs Help, Completely Unable, Met, Partially Met, and Unmet. >> Agree. We are finding that people who are new to an assessment (first time) are getting much higher SaH outcomes than those with supports already in place. It seems the IAT algorithm is not considering existing services (CHSP or transitioned HCP supports). >> Agree. There needs to be clarification around how to answer these questions when needs are being met by a carer who is also under carer stress. In these cases, the need may be 'met' but in practice it is unstable in the sense that it is totally dependent upon the carer's status. A low SaH outcome will not meet client need where the carer is unable to sustain their role.	Noted. The Integrated Assessment Tool (IAT) Classification Algorithm has been designed to consistently determine an older person's need for ongoing home support services. The algorithm ensures that people with similar characteristics and functional needs receive the same level of funding to support their aged care needs.

THEME: IAT AND OVERRIDE	
Question	**Answer**
We have heard anecdotally that some assessment orgs are routinely overriding the IAT to a higher outcome. We are concerned about a return to differing outcomes for clients across assessment organisations. We are not overriding. If others are, our clients are, in a way, disadvantaged. Will the Department have a process for ensuring fairness across all assessment orgs?	We are monitoring the override functions and will speak with organisations directly if we have concerns. The IAT outcome can only be overridden in certain circumstances.
If a delegate can see the IAT input is higher than clinically justified, are we allowed to reduce the level based on clinical need? >> Can delegates correct IAT errors or override incorrect outcomes? >> Will the system allow correction of IAT after finalisation?	The delegate can't override in these circumstances- they need to ensure the IAT is completed accurately
The algorithm does not seem to take in to account carer stress which is a critical factor in requiring access to services- the situation is often not sustainable in the short term let alone for 10-11 months. There is a big difference between formal support & informal support as well.	Noted. The criteria included in the algorithm are specified at s81-10 of the Aged Care Rules 2025.

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PARKING LOT

There are some questions that we are not able to respond to at the moment, as they require further investigation or input from other areas. We will respond to these as soon as we can. These questions are listed below.

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6. Can an escalation pathway be established for assessors to escalate cases to the Cwlth? Is there an escalation pathway for complex cases?

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8. In reviewing the criteria for priority, we have observed that the algorithm is not picking up the points correctly. Clients with 3-4 points (data entered correctly) are coming out as 'standard'. The help desk told us we are meant to override it. We have received the same feedback today regarding the assessor should override the priority allocation.

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For more information:

- A new Aged Care Act for the rights of older people (Fact Sheet)
- Guide to Aged Care Law
- Registered supporter role – guide explaining role of registered supporters and options for older people
- CHSP reforms
- CHSP Program Manual 2025-27
- CHSP provider fact sheet – supporting unregistered and unassessed CHSP clients
- Support at Home Program – Services (Fact Sheet)
- Support at Home Program Manual
- New Aged Care Act for aged care residents toolkit for communicating with residents
- New regulatory model – Guidance for Allied Health Professionals

More FAQs: Assessment and the new Aged Care Act - Frequently Asked Questions - All Items

Australian Government
Department of Health, Disability and Ageing

Assessment Organisation Forum

6 November 2025

Feedback themes:

s22

- IAT classification algorithm override – "this is a significant change that occurred at the last minute and has created a lot of confusion for assessors".

Below are responses to the questions received during the forum, grouped by theme.

THEME: SUPPORT AT HOME AND CHSP	
Question	**Answer**
Can SaH be accepted alongside TCP? MAClearning Part 2 notes TCP can be recommended alongside an IAT outcome of CHSP or SaH.	As much as possible, the older person should be recommended TCP only and then have a reassessment of their care needs towards the end of their TCP period to establish their ongoing care requirements. Where this is necessary, the assessor should review any changes to the person's care needs and ensure that the ongoing care recommendations reflect the revised level of need and the person's preferences. See: Section 6.8.2 of the Aged Care Assessment Manual.

THEME: SUPPORT AT HOME AND CHSP	
Question	**Answer**
	In very limited circumstances, an assessor may recommend that the older person for both ongoing Support at Home (SaH class 1-8) and TCP concurrently, provided the IAT classification algorithm generates a Support at Home classification. If an assessment and approval for SaH classification (1–8) occurs in hospital, the IAT classification algorithm outcome must be accepted in line with section 81-10 of the Aged Care Rules 2025. Note that a participant may also continue accessing Support at Home services while receiving TCP services, as long as there is no duplication of services between the programs. For example, a participant may choose to continue personal care services under Support at Home, while they receive allied health services under TCP. See: Section 18.3 of the Support at Home Program manual.
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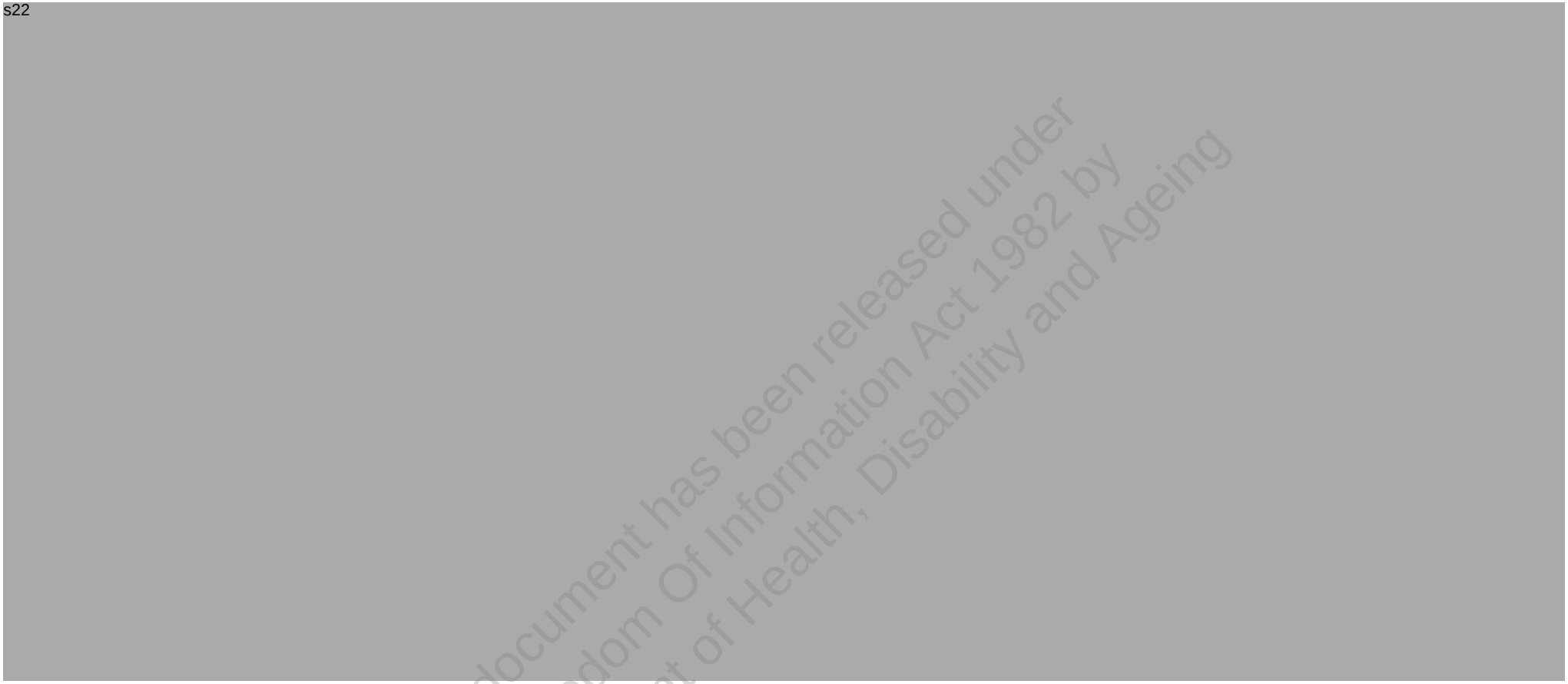

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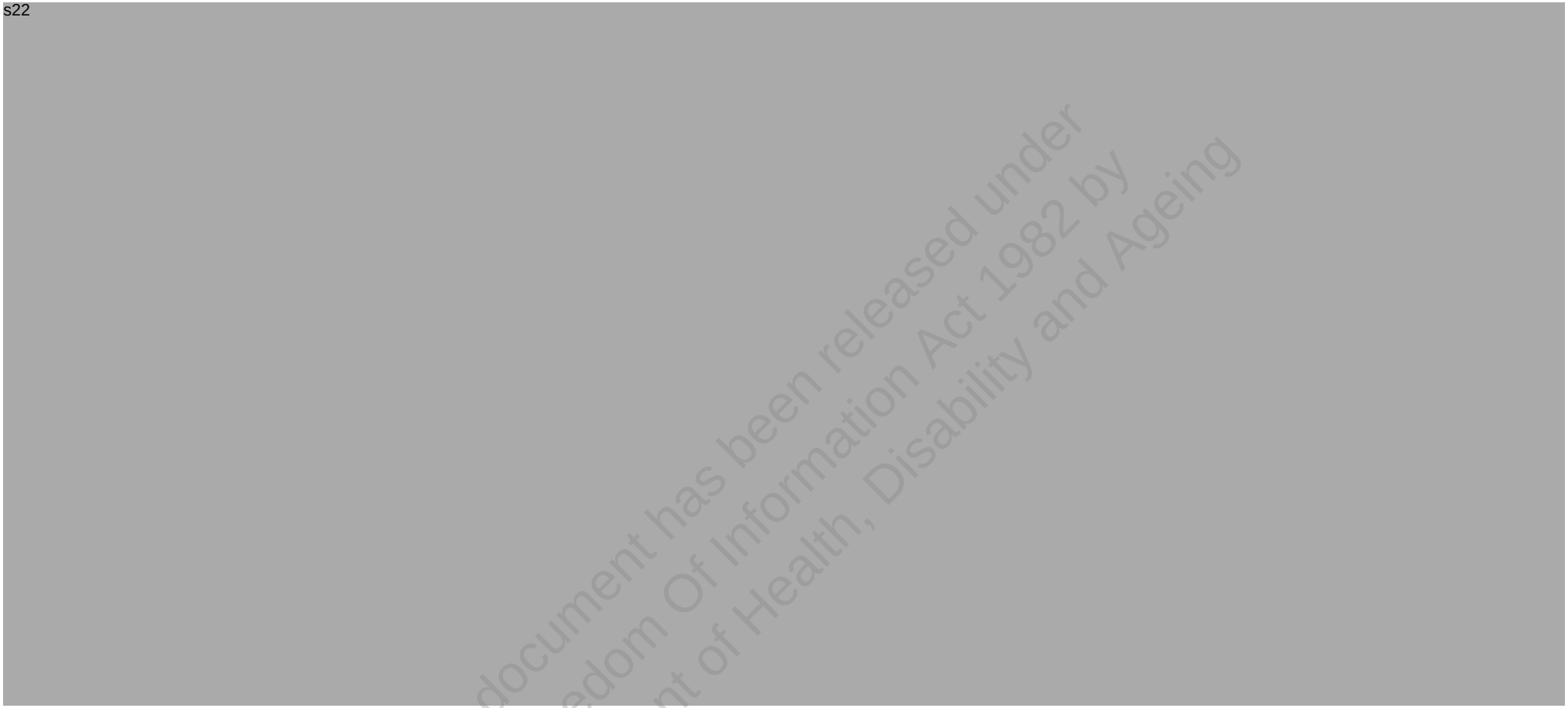

THEME: IAT AND OVERRIDE	
Question	**Answer**
If the delegate disagrees with the override from the assessor is that not a non-approval within the Notice of Decision Letter?	No, this is not a non-approval within the Notice of Decision. If the assessor has overridden the IAT outcome in favour of a lower or higher ongoing home support classification, this needs to be reversed and the original IAT outcome restored. The delegate may return the assessment to the assessor to do this, or the delegate may use the function available to them and restore the IAT outcome. At a minimum, the delegate should ensure they have discussed the requirement for the assessor to accept the ongoing home support IAT outcome.
Does the area a client lives in impact on the algorithm? We're finding in s47E(d) , where there are not many CHSP services that the recommendation is SaH.	The IAT classification algorithm does not consider the area in which the person is based.
Wouldn't it be better to send back to the assessor who could edit the override and indicate the original IAT outcome?	The delegate may return the assessment to the assessor to restore the IAT outcome to the original outcome, or the delegate can restore the IAT outcome themselves using the available functionality within the Portal. At a minimum, the delegate should ensure they have discussed the requirement for the assessor to accept the ongoing home support IAT outcome.
Is the SaH level underpinned by the use of the 11 screening tools?	Yes, they help inform the classification level. IAT classifications are based on the older person's responses to questions in the 'Functional', 'Cognition', 'Medical and Medications', 'Psychological', 'Social', 'Carer' and Physical, Personal Health and Frailty' domains in the IAT. Reponses hold a value that help calculate a total score for the older person, which informs the level of classification (including whether they have entry-level needs only or require more complex care under Support at Home).

THEME: ROLES AND TRAINING	
Question	**Answer**
Will the delegate training and role be reviewed given it may be mostly redundant to require delegation if the algorithm is determining levels/priorities and assessors are unable to override this?	While the IAT outcome is a key part of the aged care assessment process, it represents only one aspect of the Clinical Assessment Delegate's responsibilities. The IAT provides a recommendation for CHSP or Support at Home (SaH) classification levels; however, under the *Aged Care Act 2024*, Clinical Assessment Delegates hold broader legal authority to make decisions, including: • Approving access to funded aged care services under section 65(1) of the Act. • Determining service groups, classification types, and levels, ensuring all prescribed criteria are met. • Approving extensions for Transition Care and Residential Respite Care, where applicable. • Considering and approving changes to access approvals following Support Plan Reviews or reassessments. • Ensuring all decisions are legally sound, evidence-based, and properly documented in accordance with section 79 of the Act. While assessors and delegates are generally required to accept the IAT outcome, there are defined and legitimate circumstances—outlined in the *Aged Care Assessment Manual*—where overriding the IAT recommendation is appropriate. This includes situations such as recommending the Restorative Care Pathway, End-of-Life Pathway, or residential care without ongoing in-home services. To ensure ongoing alignment with these legal responsibilities, the Clinical Assessment Delegate Decision-Making training element has been revised. This update will reaffirm the role's legal boundaries, functions, and expectations. No major changes are anticipated except for management of the IAT outcome when CHSP and SaH are being recommended. The revised element was released on Friday, 28 November 2025.
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For more information:

- A new Aged Care Act for the rights of older people (Fact Sheet)
- Guide to Aged Care Law
- Registered supporter role – guide explaining role of registered supporters and options for older people
- CHSP reforms
- CHSP Program Manual 2025-27
- CHSP provider fact sheet – supporting unregistered and unassessed CHSP clients
- Support at Home Program – Services (Fact Sheet)
- Support at Home Program Manual
- New Aged Care Act for aged care residents toolkit for communicating with residents
- New regulatory model – Guidance for Allied Health Professionals

More FAQs: Assessment and the new Aged Care Act - Frequently Asked Questions - All Items

Australian Government
Department of Health, Disability and Ageing

Assessment Organisation Forum

05 February 2026

Below are responses to the questions received for 5 February Forum grouped by theme.

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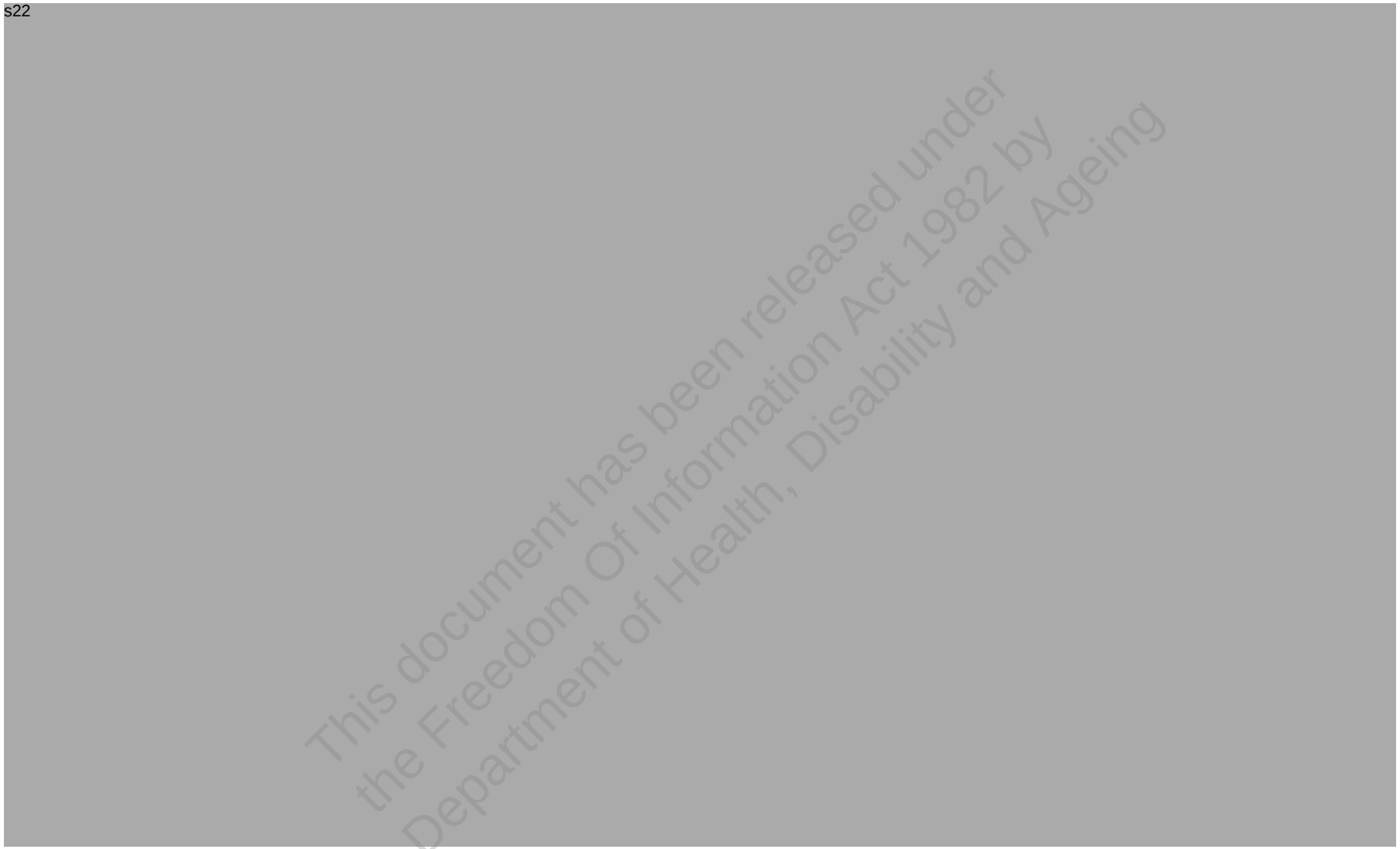

s22 [redacted]

Integrated Assessment Tool (IAT), IAT Classification algorithm and SaH Priority algorithm		
17	Clinical assessors are still asking for more guidance about completing the IAT. It is still the case whereby they could tick almost identical boxes, but SaH outcome and priority is completely different between clients– wasn't there meant to be some guidance from the Dept coming out about this??	The IAT Classification algorithm ensures that people with similar clinical characteristics receive the same level of funding to support their aged care needs. For a given set of clinical characteristics, the algorithm will always generate the same outcome. The department has recently provided assessment organisations with further guidance on the operation of the IAT Classification algorithm. Please refer to guidance sent to Assessment Organisation operational and training Managers on

		30 January 2026 titled *IAT Classification Algorithm – Factsheet and FAQs* (C213). The SaH priority algorithm draws on the same data points in all assessments in the client's record and the two questions in the IAT. These criteria are outlined in section 7.9.1 of the Aged Care Manual.
18	Overriding the IAT outcome option – will there be capacity for maybe even just delegates to override the IAT outcome if it clearly incorrect?	The criteria for each classification level are detailed in section 81-10 of the *Aged Care Rules 2025.* The Rules do not allow for the outcome of the IAT Classification algorithm to be overridden to a different ongoing home support classification. The creation over an override discretion for the IAT Classification algorithm would require a decision of Government and amendment to the *Aged Care Rules 2025*. The department is monitoring the operation of the reforms to inform advice to Government. If a delegate is concerned about the classification level an older person is assigned assessment organisations can share their feedback with the department via MyAgedCare.Assessment@health.gov.au or at their regular contract management meetings with the department. If an older person is concerned about the IAT Outcome, they can request a review of the classification decision within 28 days of receiving their notice of decision.
19	Is there an ETA on when the Clinical delegates (or potentially clinical assessor supervising conversion) can re-open an IAT post finalised status to edit?	The department is actively exploring this option however we are not in a position to confirm the nature or timing of any potential change at this time. We will communicate further information as soon as we can.

20	Priority algorithm doesn't take into account some people who don't live alone, but the person they live with cannot assist with any care needs due to their own health/cognitive issues. Can this be looked at a future review?	The department is monitoring the performance of the SaH Prioritisation Algorithm and is carefully considering all feedback on how it is working to inform advice to Government on whether amendments are required.
21	Carers need to be factored into the Algorithm	Thank you for your feedback. Carer arrangements are not a standalone criterion within the SaH Prioritisation Algorithm, but the 'requires urgent service provision' question is intended to capture this. The Assessment Manual provides guidance on this question. An unsustainable caring arrangement is a situation in which a Yes response may be given to this question. The department is monitoring the performance of the SaH Prioritisation Algorithm and is carefully considering all feedback on how it is working to inform whether amendments are required.
22	When will the IAT User Guide be updated please. The recent guidance doesn't have any timeframe	Version 2.4 of the IAT User Guide, published 1 November 2025, is available on the department's website. The department updates the IAT User Guide as required to align with ICT changes or emerging issues. The department will advise all assessment organisations of any updates to the IAT User Guide when updates are made.
23	If a HSA doesn't trigger clinical questions but results in a SAH classification- it begs the question that the algorithm is not working as intended. It follows that clients have higher needs that are also not being reflected the other way.	The IAT Classification Algorithm takes into consideration a person's functional ability, the extent to which their care needs are being met, and compounding factors that may increase the care needs of someone in comparison to others with similar functional ability and needs met score. Both clinical and non-clinical questions in the IAT are considered in the IAT Classification Algorithm. Therefore, not triggering clinical

		questions is not an indicator that the algorithm is not working as intended.
24	Re quality assurance, it is great you are doing this, but given we can't override the IAT and the number of conversions is so high, are you considering starting at the lower S@H levels?	The department will be reviewing SaH classifications 1 and 2 as part of future assurance activities.
25	Question relating to Factsheet "Understanding the IAT Classification Algorithm" 1. **Page 3:** "Importantly, delegates remain responsible for reviewing and approving assessments ensuring decisions are legally sound, evidence-based and meet eligibility requirements. When undertaking their role, delegates must be satisfied that an older person meets the eligibility criteria for all recommended aged care programs, as the IAT Classification Algorithm outcome cannot determine this in the place of a delegate". **Is this comment related to decision making after the IAT outcome and should this include the system functionality to agree or disagree as delegates as they have no way to request any changes to the outcome? In addition, does the advice here, not contradict the following question on page 4: Why can't a different classification level than that generated by the IAT Classification Algorithm be recommended and approved?** **Page 3 –** In relation to this statement - *For a given set of clinical characteristics, the IAT Classification Algorithm will always generate the same classification level*. **What evidence is there that similar clients receive a similar IAT outcome** -this is not currently our experience. **How is this is being monitored and that the statement is based in fact – please provide data?**	Once an aged care needs assessment is undertaken, the assessment delegate must ensure that all eligibility requirements are met before approving any service group, service type, or specific funded aged care service. This means that the older person's situation must meet the conditions outlined in sections 66 to 68 of the *Aged Care Act 2024*, and any additional eligibility criteria set by the relevant *Aged Care Rules 2025* must be satisfied. This eligibility criteria includes criteria of a classification level outcome for ongoing home support services. If these requirements are not met, the assessment delegate cannot approve the provision of aged care services. For a given set of clinical characteristics across the functional needs, needs met and compounding factors, the IAT Classification Algorithm will always generate the same outcome.

	- *Assessment delegates must ensure that the classification level for ongoing home support services and the IAT Classification Algorithm outcome is the same.* - could the Commonwealth please clarify what this sentence means? Are they saying that we cannot override the outcome?	
26	Question relating to Factsheet "Understanding the IAT Classification Algorithm" 2. **Page 6- Will this example be paid at Comprehensive?** There are instances where Home Support Assessment triaged a Home Support and it is clear they are CHSP but the SAH 1 is the outcome. There is a fine line between CHSP and SAH 1. **Page 6 – How is it acceptable that Home Support Assessors are now recommending Support at Home and not CHSP only because of IAT outcomes?** Many of these clients can manage on CHSP whereby they will get a higher level of service under CHSP than they will under S@H levels 1 and 2. Clients have a preference for CHSP and can manage with basic supports. **Is this issue going against the reduction in funding that the IAT is intending – granting higher funding to those who only need basic supports?**	Assessments will continue to be paid based on the assessment type at triage. Thank you for this feedback. The department will be reviewing SaH classifications 1 and 2 as part of future assurance and policy activities.
27	Question relating to Factsheet "Understanding the IAT Classification Algorithm" 3. **Page 7**- assessment in usual place of residence. The example they give for residential transition care does not make sense. **If it instead stated "current accommodation setting"; it would make sense. Furthermore re this point, can you advise if an**	Thank you for this comment. There are system and legislative limitations regarding reducing a person's classification level after a period of transition care. We therefore recommend that for new clients to the aged care system, the IAT outcome is overridden to 'ineligible for CHSP/SaH' to recommend TCP and the client be reassessed for ongoing home support (if appropriate) toward the

	assessment has to occur eg hospital setting pre TCP, does the system have capability that a subsequent assessment in the person's usual accommodation setting ie their home post TCP result in a reduced SAH class? (Given the client has presumably improved from the TCP intervention). Is this example for post TCP?	end of their transition care period. If this is not appropriate, TCP can be recommended alongside ongoing home support so long as the algorithm generated a CHSP or SaH classification. For older people with a Transitioned HCP or Support at Home access approval, the IAT Classification Algorithm will need to be accepted when assessed for transition care in a hospital setting.
28	Question relating to Factsheet "Understanding the IAT Classification Algorithm" **4. Page 10 - Can the Commonwealth advise – does the algorithm have the capability to at the point of next assessment post TCP – reduce the over-ridden SAH class level in recognition of functional improvement whilst on TCP or not?**	Thank you for this comment. There are system and legislative limitations regarding reducing a person's classification level after a period of transition care. We therefore recommend that for new clients to the aged care system, the IAT outcome is overriden to 'ineligible for CHSP/SaH' to recommend TCP and are reassessed for ongoing home support (if appropriate) toward the end of their transition care period. If this is not appropriate, TCP can be recommended alongside ongoing home support so long as the algorithm generated a CHSP or SaH classification. For older people with a Transitioned HCP or Support at Home access approval, the IAT classification algorithm will need to be accepted when assessed for transition care in a hospital setting.
29	Question relating to Factsheet "Understanding the IAT Classification Algorithm" If we escalate IAT algorithm outcomes that are concerning, what is the follow up process? Does this mean the outcome will be reviewed by the Cwlth and the possibility of the outcome to override??	If a delegate is concerned about the classification level an older person is assigned assessment organisations can share their feedback with the department via MyAgedCare.Assessment@health.gov.au or at their regular contract management meetings with the department. The Single Assessment System branch will share this feedback with our colleagues responsible for the algorithm for their consideration.

	Can you please advise what we expect in response to any IAT algorithm classification outcomes that may be escalated to you. We look forward to receiving details in respect to the escalation process for our awareness and discussions with our assessment agencies	
30	How can we progress a request to Government to make a change to the Aged Care Rules regarding override of IAT outcomes?	As advised at the forum, the department welcomes feedback on how the arrangements are operating, including suggestions for improvements, to inform our advice to government.
Assessment process and requirements		
s22	[redacted]	

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s22 [redacted]

PARKING LOT
There are some questions that we are not able to respond to at the moment, as they require further investigation or input from other areas. We will respond to these as soon as we can. These questions are listed below.

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[redacted]

2. Question relating to Factsheet "Understanding the IAT Classification Algorithm"

The "Rules" talks about "functional independence" and "needs met" score, which I assume is drawn from the IAT responses however we can't find more detail on this, could you please advise?

Classification levels and criteria		
Item	**Column 1 Classification level**	**Column 2 Criteria**
1	CHSP class	Any of the following: (a) the individual: (i) has a functional independence score of 42-48; and (ii) has a needs met score of 35 or 36; (b) the individual: (i) has a functional independence score of 42-48; and (ii) has a needs met score of 0-34; (c) the individual: (i) has a functional independence score of 35-41; and (ii) has a needs met score of 31-36; (d) the individual: (i) has a functional independence score of 35-41; and (ii) has a needs met score of 0-30; and (iii) does not have significant compounding factors
2	SAH class 1	Either: (a) the individual: (i) has a functional independence score of 35-41; and (ii) has a needs met score of 0-30; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 30-34; and (ii) has a needs met score of 30-36; and (iii) does not have significant compounding factors
3	SAH class 2	Either: (a) the individual: (i) has a functional independence score of 30-34; and (ii) has a needs met score of 30-36; and (iii) has significant compounding factors; or (b) the individual: (i) has a functional independence score of 30-34; and (ii) has a needs met score of 0-29; and

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For more information:

- A new Aged Care Act for the rights of older people (Fact Sheet)
- Guide to Aged Care Law
- Registered supporter role – guide explaining role of registered supporters and options for older people
- CHSP reforms
- CHSP Program Manual 2025-27
- CHSP provider fact sheet – supporting unregistered and unassessed CHSP clients
- Support at Home Program – Services (Fact Sheet)
- Support at Home Program Manual
- New Aged Care Act for aged care residents toolkit for communicating with residents
- New regulatory model – Guidance for Allied Health Professionals

Australian Government
Department of Health, Disability and Ageing

Review of IAT Classification Algorithm Overrides

A review has commenced on assessments where the IAT classification algorithm's has been overridden for ongoing home support services. Some trends have begun to emerge, broadly covering the following 5 key areas.

Key Findings

1. Frequent Overrides for Higher-Level Service Needs

- In the majority of cases, the reason selected for overriding to another classification level was "Higher level service needs", often associated with the following specific conditions and scenarios:
    - Cognitive decline and challenging behaviours
    - Complex medical conditions requiring medication management, nursing, and personal care
    - Progressive neurodegenerative disorders and recent strokes
    - Unsafe living environments and high carer stress
    - Current HCP levels (often Level 3 or 4) were fully expended or inadequate.

While these represent the reasons given for the override, it's important to note that overriding for higher level service needs is not permitted under section 81-10 of the Aged Care Rules 2025.

2. Misalignment Between IAT Data and Narrative Notes

- In several cases, the inputs recorded in the IAT did not align with assessor observations of high care need. For example, IAT response options such as "with some help" were selected however this conflicted with free-text descriptions indicating higher dependency.
- This has been observed across several components of the IAT and is particularly prevalent in discrepancies associated with the Carer's Profile.

3. Missing or Incomplete Override Documentation

- Multiple instances were identified where no override reason was recorded in Siebel, even though a significant change in recommended outcome occurred. In these cases, the absence of a reason was linked to two assessments being completed to upgrade the outcome.
- Where descriptions were provided, they often did not align with permitted override reasons. For example, comments such as 'previous package has run out of funding', 'HCP needs met - over budget' were recorded.
- Some assessments were marked as "Accepted" despite the changed classification level.

4. Repeated Assessments Within Short Timeframes

- In several instances two assessments were conducted only days apart, with differing IAT responses and outcomes. It appears that assessors are initially accepting the IAT outcome generated by the algorithm and then conducting a reassessment, modifying responses within the IAT to achieve a different classification level.

5. Other Quality Concerns

- Data and documentation inconsistencies where prevalent, including missing records, with Notice of Decision letters and support plans absent in multiple finalised assessments.

Next Steps

This review is continuing, and we would be happy to share further findings in future forums.

Australian Government
Department of Health, Disability and Ageing

Understanding the IAT Classification Algorithm

January 2026

The *Aged Care Act 2024* (the Act) has changed the way funding levels are determined for ongoing home support services.

This fact sheet is for Single Assessment System assessment organisations to provide guidance to their assessment teams on IAT classification outcomes. It provides information on the IAT Classification Algorithm and aims to build knowledge and understanding of what the algorithm does, why it was built, and provides guidance on how to interact with the IAT Classification Algorithm outcome in various scenarios.

Aged Care Service Approvals under the Act

To best understand the IAT Classification Algorithm, it is important to first understand where it fits in the legislative framework and how it contributes to an individual's approval to access government funded aged care services. The Act describes and groups together approvals differently than the previous *Aged Care Act 1997*. Rather than focusing on aged care programs, approvals under the *Aged Care Act 2024* revolve around three primary components that, when combined, are comparable to 'being approved for a program' under the *Aged Care Act 1997*. The components are 'Service group', 'Classification type' and 'Classification level' (sometimes simply referred to as 'Classification'). A priority category is also applied in some circumstances.

- **Service groups** specify the setting and nature of care an individual can access. There are four service groups: home support, assistive technology, home modifications and residential care.
- **Classification types** differentiate the time period that services are delivered 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.
- **Priority categories** are applied in some circumstances to determine how older people are prioritised for funding.

To understand how this looks in practice, a person who has been assessed as needing access to ongoing home support services will be approved for:

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

To give an example for comparison, a person who has been assessed for permanent residential care will be approved for:

- **Service group:** Residential Care
- **Classification type:** Ongoing
- **Classification level:** Class 0 or Class 1-13

Further information about the structure of aged care approvals can be found in Chapter 1 of the Aged Care Assessment Manual.

What does the IAT Classification Algorithm do?

The IAT Classification Algorithm (which generates the IAT Outcome in the assessor portal) determines two things:

- An older person's eligibility (or ineligibility) for ongoing home support services i.e. Service group: Home support, Classification type: ongoing.
- An older person's classification (funding) level i.e. CHSP class or Support at Home classifications 1-8.

Why has the IAT Classification Algorithm been introduced?

The IAT Classification Algorithm has been introduced to ensure that people with similar characteristics and functional needs receive the same level of support. It has been designed to:

- **Achieve consistency –** so that decisions are not influenced by individual discretion or subjective judgement.
- **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.

How does the IAT Classification Algorithm work?

The IAT Classification Algorithm is guided by a set of rules that are built into the IAT to generate a classification (funding) level. It considers an older person's needs at three levels:

- Identification of their functional abilities,
- Assessment of how well their functional needs are currently being met, and
- Consideration of compounding factors, which allows the algorithm to differentiate between people with similar functional status and level of met needs.

The IAT Classification Algorithm is a set of rules that takes the responses that an assessor enters into the IAT across the Carer, Medical and Medications, Function, Physical, Personal

Health and Frailty, Social, Cognition and Psychological domains to understand an older person's clinical characteristics. From these inputs it determines an older person's classification level for ongoing home support services. For a given set of clinical characteristics, the IAT Classification Algorithm will always generate the same classification level.

The criteria for each classification level are detailed in section 81-10 of the Aged Care Rules 2025.

How was the IAT Classification Algorithm developed?

The algorithm was developed from analysis of the 22,000 aged care assessments that were undertaken using the IAT during the IAT Trial. The data used in developing the algorithm was independently assessed to ensure it was valid, reliable and fit for purpose. A panel of clinicians was convened to independently review a draft funding framework and algorithm, and the results of this review were used to refine the funding framework and algorithm.

The department is monitoring and regularly reviewing the algorithm to ensure it is working as intended.

What role do assessors play in the outcome of the IAT Classification Algorithm.

The outcome of the IAT Classification Algorithm relies on information that has been entered into the IAT during the assessment. Assessors play a critical role in achieving high quality assessment outcomes by using their strong communication and interpersonal skills to complete the IAT during the assessment, and their clinical judgement when undertaking comprehensive assessments. It is important for assessors to follow the guidance in the Aged Care Assessment Manual, IAT User Guide and Aged Care Assessment Quality Framework to achieve high quality assessments. Training modules are also available through MACLearning and can be revisited at any time.

What role do assessment delegates play in the outcome of the IAT Classification Algorithm.

Assessment delegates must ensure that the classification level for ongoing home support services and the IAT Classification Algorithm outcome is the same.

Importantly, delegates remain responsible for reviewing and approving assessments ensuring decisions are legally sound, evidence-based and meet eligibility requirements. When undertaking their role, delegates must be satisfied that an older person meets the eligibility criteria for all recommended aged care programs, as the IAT Classification Algorithm outcome cannot determine this in the place of a delegate. Delegates must also be satisfied that all care types recommended in an older person's support plan reflect the older person's assessed needs and goals.

Why can't a different classification level than that generated by the IAT Classification Algorithm be recommended and approved?

Section 81-10 of the Aged Care Rules 2025 (the Rules) describes the criteria that must be met for each classification level. The Rules are prescriptive and do not allow for an ongoing classification level to be approved that is different to the criteria it describes and which the algorithm is based on.

In practice, this means that 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 Classification Algorithm outcome that is generated by the system must be accepted by the assessor. For example, where the IAT Classification Algorithm outcome recommends an ongoing SaH class 5 the assessor must accept this outcome to operate in line with the legislation.

Where can I find further information about how to treat the IAT Classification Algorithm outcome to recommend different aged care programs?

The following Frequently Asked Questions aim to provide guidance for assessors and delegates on how to treat to the IAT Classification Algorithm outcome in various scenarios. The FAQs have been themed into three categories for ease of reference:

- ongoing home support services
- short-term pathways without ongoing home support services
- short-term and residential aged care pathways alongside ongoing home support services

Australian Government
Department of Health, Disability and Ageing

IAT Classification Algorithm FAQs

This section collates frequently asked questions about the IAT Classification Algorithm to help assessors and assessment delegates better understand how these changes impact their assessment activities.

Recommending ongoing home support services

The following questions and responses relate to the IAT Classification Algorithm outcome and recommending ongoing home support services.

Question	Response
What should assessors do if they intend to recommend ongoing home support services?	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 be accepted by the assessor. For example, where the IAT Outcome recommends an ongoing SaH 5 the assessor must accept this IAT Outcome.
If the IAT Outcome for an older person new to the aged care system is 'ineligible for CHSP/SAH' can the outcome be overridden to CHSP?	For older people new to the aged care system, if the IAT Outcome results in 'ineligible for CHSP/SaH', the person is not eligible to receive CHSP or SaH. In this circumstance the system will display a prompt to override to a higher classification. Assessors must not take this action. If, after reviewing the evidence collected during the assessment and the eligibility criteria in the *Aged Care Act 2024* and *Aged Care Rules 2025*, the assessor intends

Question	Response
	to recommend residential care, it is appropriate to accept the ineligibility outcome and proceed with the residential care recommendation. Assessors and delegates can also refer someone who has been found 'ineligible for CHSP/SaH' to local health or community services provided by government and community organisations.
When reassessing an older person with a transitioned Home Care Package (HCP) level classification, what action should be taken if the IAT Outcome generates a classification level that is lower than their transitioned HCP level?	When reassessing transitioned HCP clients, assessors will need to ensure that they maintain the transitional classification where it is more beneficial for the older person. This will be flagged in the system on reassessment. If the IAT outcome is a lower classification than the existing active ongoing classification, then a warning message will display to inform the assessor that they can retain the existing classification by clicking the accept button. If the warning message appears on a client's profile, assessors should accept the IAT Outcome ensuring the client retains their transitional classification. Assessors should encourage the older person to work with their provider to re-package their existing services.
Where the classification algorithm outcome of a home support assessment is a Support at Home classification, does the assessment need to be converted to a comprehensive assessment if clinical questions are not triggered in the IAT during the assessment?	Yes. Where the assessment was triaged as a home support assessment and results in an IAT Outcome of Support at Home classification 1-8, the assessment must be converted to a comprehensive assessment under the supervision of a staff member holding a clinical assessor role in the system. This supervision is not the same as the clinical attendance process outlined in section 5.7 of the Aged Care Assessment Manual. Rather, it is a conversation between assessors to ensure the support plan reflects the needs of the older person and the appropriate care recommendations are included for delegate approval. There is no requirement for the assessment to be undertaken again by the clinical assessor.
Can an assessor recommend CHSP services alongside SaH, if the IAT Outcome generates a SaH classification?	An assessor can recommend CHSP services alongside Support at Home if the IAT Outcome generates a SaH classification level. In this circumstance the IAT Outcome should be accepted, and the assessor selects 'add a service

Question	Response
	recommendation' button to add CHSP services. Once a person receives Support at Home funding there are limited circumstances where a person can receive CHSP services alongside Support at Home. See Chapter 6 of the Aged Care Assessment Manual.
What happens if a delegate approves a different classification level to that which is generated by the IAT Outcome?	Delegates remain responsible for reviewing and approving assessments ensuring decisions are legally sound, evidence-based and meet eligibility requirements. This includes ensuring an older person meets the eligibility criteria set out in the *Aged Care Rules 2025* for the classification level of ongoing home support they are approved for. Section 81-10 of the Rules is prescriptive in the eligibility criteria for each classification level and does not allow for a different IAT Outcome to be recommended or approved. If a delegate approves a different classification level to the IAT Outcome, this should be escalated to the department for correction. See Chapter 11 of the Aged Care Assessment Manual for the corrections process.
When assessing an older person for ongoing home support outside of their usual accommodation setting (e.g. in a hospital or residential transition care setting), what action should be taken by the assessor to ensure the IAT Outcome is accurate?	It is best practice for an older person to be assessed for ongoing home support services in their usual accommodation setting. This will assist with the environmental, physical and social components of the assessment by observing the older person's level of independence, function and existing support arrangements in familiar settings. It is acknowledged that some assessments for ongoing home support will occur in hospital or transition care settings as it is not always possible to conduct an assessment in an older person's usual accommodation setting. In cases where an older person is not being assessed in their usual accommodation setting (e.g. hospital or residential transition care), the assessor should aim to complete a 'true' assessment based on functional needs in the home environment, not the setting they are temporarily in. Section 5.5.4 of the Aged Care Assessment Manual emphasises that hospital-based assessments should include consideration of the home environment. Where necessary, assessors should seek input from the older person's care team to accurately understand their home environment and

Question	Response
	functional needs to make an as accurate assessment as possible of their care needs.
If an older person's care/support arrangements are unstable and unlikely to provide ongoing support, is it permissible for an assessor or delegate to override the IAT Outcome?	Assessors should ensure an older person's care and support arrangements are accurately captured in the IAT. If the assessor, based on the evidence collected during the assessment, intends to recommend ongoing home support, the outcome generated by the IAT Classification Algorithm must be accepted by the assessor. Assessors and delegates should consider other care types and linking supports that will provide additional support.

Recommending short-term and residential aged care pathways without ongoing home support services

The following questions and responses relate to the IAT Classification Algorithm outcome and recommending short-term pathways without ongoing home support services.

Question	Response
Can assessors recommend short-term pathways without ongoing home support services?	Assessors can recommend funded aged care services for an older person including short-term home support pathways without recommending ongoing home support. In these circumstances an assessor can override the IAT Outcome to the relevant short-term home support pathway or residential care. Assessors may override to the following care types: • Restorative Care Pathway (RCP) • End-of-Life Pathway (EoL) • Transition Care Program If an assessor intends to override the IAT Outcome to only recommend RCP and the place cap has been reached time-limited reablement services under CHSP should be considered.
Can assessors recommend residential care without ongoing home support services?	Assessors can recommend funded residential care services for an older person without recommending ongoing home support. In these circumstances an assessor can override the IAT Outcome to recommend permanent residential care or residential respite.
Can assessors override an IAT Outcome of CHSP to recommend RCP or EoL?	If the IAT Outcome is CHSP the classification cannot be overridden to RCP or EOL.

Recommending short-term pathways alongside ongoing home support services

The following questions and responses relate to the IAT Classification Algorithm outcome and recommending short-term pathways alongside ongoing home support services.

Question	Response
Can CHSP services be recommended alongside TCP?	If an assessor wants to recommend CHSP services alongside TCP, the IAT Outcome should be overridden to 'ineligible for CHSP/SaH'. TCP should then be added as a care type. The assessor is then able to recommend CHSP services using the 'add a service recommendation' button. CHSP services recommended cannot be duplicative of services the older person receives through TCP.
Can an assessor recommend SaH and TCP at the same time?	As much as possible, the older person should be recommended TCP only and then have a reassessment of their care needs towards the end of their TCP period to establish their ongoing care requirements. Where this is necessary, the assessor should review any changes to the person's care needs and ensure that the ongoing care recommendations reflect the revised level of need and the person's preferences. See: Section 6.8.2 of the Aged Care Assessment Manual. In limited circumstances, an assessor may recommend that the older person for both ongoing Support at Home (SaH class 1-8) and TCP concurrently, provided the IAT classification algorithm generates a Support at Home classification. If an assessment and approval for SaH classification (1–8) occurs in hospital, the IAT classification algorithm outcome must be accepted in line with section 81-10 of the Aged Care Rules 2025. Note that a participant may also continue accessing Support at Home services while receiving TCP services, as long as there is no duplication of services between the programs.

	For example, a participant may choose to continue personal care services under Support at Home, while they receive allied health services under TCP. See: Section 18.3 of the Support at Home Program manual.

Operation of the IAT Outcome and escalating concerns

The following questions and responses relate to the operation of the IAT Outcome and actions that should be taken assessors or delegates to escalate concerns to the department.

Question	Response
What action should be taken if the assessor or delegate is concerned that the ongoing home support classification generated by the IAT Classification Algorithm is insufficient to meet the older person's needs?	Assessment organisations can escalate their concerns to the department via MyAgedCare.Assessment@health.gov.au or at their regular contract management meetings with the department. If the client is concerned about the IAT Outcome, they can request a review of the classification decision within 28 days of receiving their notice of decision.
How do assessors communicate the classification level outcome that is generated by the IAT Classification Algorithm with older people?	Section 5.7.7 of the Aged Care Assessment Manual provides tips to assessors on how to explain the IAT outcome and recommended classification level to an older person. It is important that assessors do not include commentary in the support plan or Notice of Decision that suggests the algorithm outcome is wrong or the system is not working as it should. This instils worry and distrust and creates unrealistic expectations of the Review of Decisions process. Per the question above, if an assessor is concerned with the IAT outcome, their assessment organisation can escalate these concerns to the department.

Question	Response
How can assessment organisations ensure the consistency of assessor inputs into the IAT across the Single Assessment System workforce?	The guidance available in the IAT User Guide is best practice and will continue to be refined over time. Refinements will continue to be made to the IAT User Guide following feedback from assessment organisation governance channels and the Lead Educator Network. Our quality assurance work will also continue to inform changes, as well as feedback from the department's Review of Decisions team. We encourage assessors to continue to use their best judgement, with support of resources including the Aged Care Assessment Manual, IAT User Guide and training modules.

Australian Government
Department of Health and Aged Care

Aged Care Act 2024
Guide for the Single Assessment System Workforce

May 2025

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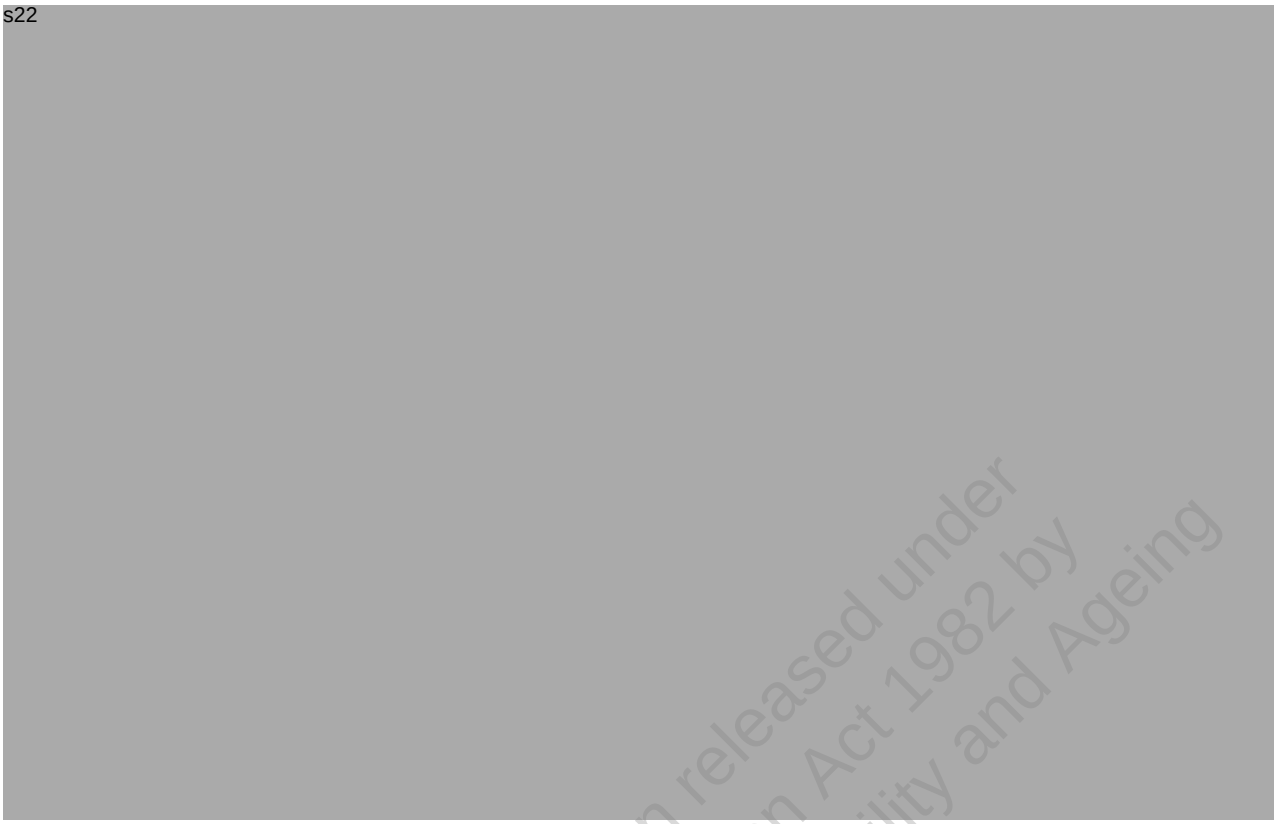

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Chapter 5: Needs Assessment

What you'll find in this chapter

This chapter includes important information about how to complete a support plan for an older person and outlines the different services and programs that can be recommended depending on an older person's needs and goals.

This part of the aged care needs assessment presents the biggest change to processes and guidelines for assessors and assessment delegates. The changes discussed include:

During an assessment:

- Registering a supporter
- Completing all mandatory questions and finalising an assessment in the IAT
- Undertaking an assessment for someone who is already accessing aged care services through alternative entry

Developing a support plan:

- Accepting or overriding an IAT outcome
- Recommending service types and services
- Recommending that any services approved can be delivered by a provider under the MPS or NATSIFAC programs
- Understanding the new automated priority category associated with ongoing Support at Home and residential care

Changes to Aged Care Programs:

- Introduction of Support at Home, which includes:
  - Classifications (Levels 1 – 8)
  - Restorative Care Pathway
  - End-of-Life Pathway
  - Assistive Technology and Home Modifications (AT-HM)
- CHSP
- NATSIFACP
- MPSP
- Transition Care Program (TCP)
- Residential Care

During an assessment

Registering a supporter

The *Aged Care Act 2024* establishes the role of a supporter. Registered supporters help older people to make and communicate their own decisions about aged care. This might include speaking to My Aged Care, receiving information, supporting daily aged care decisions, and communicating information for the older person.

When the *Aged Care Act 2024* commences, the registered supporter role will replace existing regular and authorised representative relationships in My Aged Care. Older people with regular and authorised representative relationships active in My Aged Care on 30 June 2025, who did not opt out, will move into supporter relationships on 1 July. If the older person or their supporters did not want to transition to a supporter relationship and did not opt out by 30 June, they can still request to end their supporter relationship at any time in their Online Account or by calling My Aged Care.

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

- completing the Registration of a Supporter form. The assessor can upload the form and any associated documentation to the client's record.
- submitting a registration request online with the assessor via the assessor portal or app, including uploading any associated documentation.

It is important to note that while assessors can collect and submit the required information, they cannot confirm or approve the registration of a supporter relationship.

Further guidance and information on the use of the supporter registration form and delegations of the supporter provisions will be provided as of 1 July 2025.

Prior to an assessment an assessor must:

- Check whether a supporter or agent for the older person has been registered or established. If the client is already registered in My Aged Care, assessors can use the assessor portal to find the client, then view their support network (if any supporter relationships have been registered).
- Check the authority of any active, appointed decision makers of the older person, if they have made themselves known to the assessor. Appointed decision makers are not required to register as supporters to exercise their legal authority under a state or territory arrangement, however this is encouraged to streamline authentication and information sharing to support older people. Assessors can engage with appointed decision makers before, or without them, formally registering as supporters, provided the assessor is satisfied they are acting within their authority. To do so, assessors should seek legal documentation that shows the person is an active, appointed decision-maker for the older person. Medical evidence about the older person may also be required to show that the decision maker's authority is active.

Undertaking aged care needs assessments using the IAT

The IAT will continue to be the tool that assessors must use to undertake an aged care needs assessment. The IAT is an assessment tool that has been designed to support skilled assessors to determine a client's aged care needs. It comprises

questions across social, physical, medical, cognitive, and psychological domains as well as home and personal safety, risk of vulnerability and support considerations.

There will be no significant changes to the wording of questions in the IAT from 1 July 2025. The significant changes will be in the support plan, with different services that can be recommended through Support at Home, which replaces Home Care Packages (HCP) and Short-Term Restorative Care (STRC), or for delivery under existing specialist aged care programs such as MPSP or NATSIFACP.

All mandatory questions must be completed and the IAT finalised by selecting 'Finalise IAT' before moving to the support plan. This is so the system can then recommend a home support classification (also referred to as a classification level under the Act), which may be a Support at Home classification or CHSP. Note that a classification level recommendation must be made even if the person later chooses to access services under MPSP or NATISFACP.

If the IAT has not been finalised, the IAT outcome and classifications will not be displayed. The assessor will not be able to recommend the person for funded aged care services.

Aboriginal and Torres Strait Islander assessment organisations will be required to use the IAT to conduct assessments and must do so in a way that is culturally safe for the region or older person.

Refer to the My Aged Care Assessment Manual and Aged Care Assessment Quality Framework for further information on how to undertake a high-quality assessment using the IAT.

Urgency ratings in the IAT

The IAT will include 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 and details to be added to a free text box. This urgency rating is required for the system to calculate a priority category for the person for the Support at Home Priority System. Please note that other information is also used to calculate a priority category.

Further guidance on how to record an urgency rating will be provided by 1 July 2025.

Developing a support plan

The most significant changes an assessor will see in the assessment process will be at the end of the assessment when they are developing a support plan and recommending services for an older person.

Home Care Packages (HCP) and Short-Term Restorative Care (STRC) will be replaced by the Support at Home program (note: HCP and STRC will still be visible

in the assessor portal for a limited time, however they will only be used in limited circumstances). Instead, assessors will recommend that a person can access one or more services under the home support service group and provide a recommended classification type and level (e.g. Support at Home (classifications 1 – 8) or Restorative Care Pathway). There will also be other new services under Support at Home, including the End-of-Life pathway. Services will also be available under the Assistive Technology (AT) and Home Modifications (HM) service groups.

As an assessor, you will still be able to recommend CHSP, residential care (permanent and respite) and transition care services (hospital transition classification type).

You will also be able to recommend any services approved be delivered through a NATSIFACP or MPSP service provider if this is relevant for the older person.

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 supports 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.

IAT Outcome

From 1 July 2025, there will be a variety of different service options an assessor can recommend. These will appear in the *Goals and Recommendations* tab of the Support Plan and Service page in the IAT.

Once an assessment is finalised, the system will generate three possible IAT outcomes for a client:

1) 'ongoing Support at Home (classifications 1 – 8),

2) CHSP (ongoing), or

3) 'ineligible' (classification 0) for either ongoing Support at Home (SAH) or CHSP.

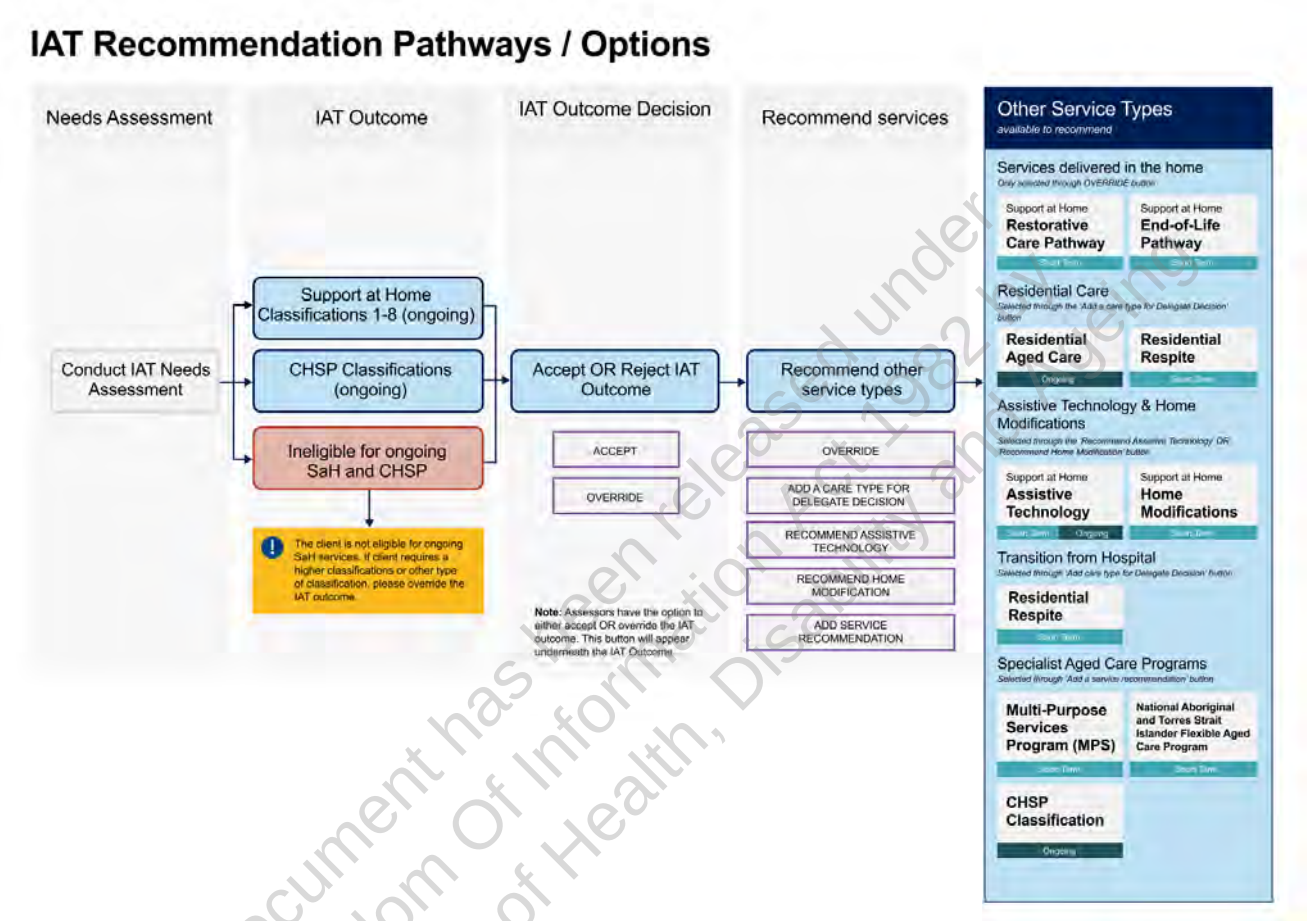
The Support at Home classification level will be based on a summary of clinical needs captured through the assessment process. The outcome with display in the *Goals & recommendations* tab.

Note: Support at Home classifications can only be recommended in a comprehensive assessment and must be sent for Clinical Assessment Delegate approval. If non-clinical assessors are undertaking a home support or 'simple' assessment, they will need to convert the assessment to 'comprehensive' and seek clinical supervision in order to recommend a Support at Home classification.

Assessors will have the option to accept or override the IAT outcome. These buttons will appear underneath the IAT outcome. It is best practice that the older person's concerns and goals are added before finalising the IAT.

Assessors can only recommend services after finalising the IAT and accepting the generated or overridden classification outcome.

The diagram below details the available pathways or service types assessors can recommend and how they navigate this in the 'Goals and Recommendations' tab of the IAT Support Plan and Service page.



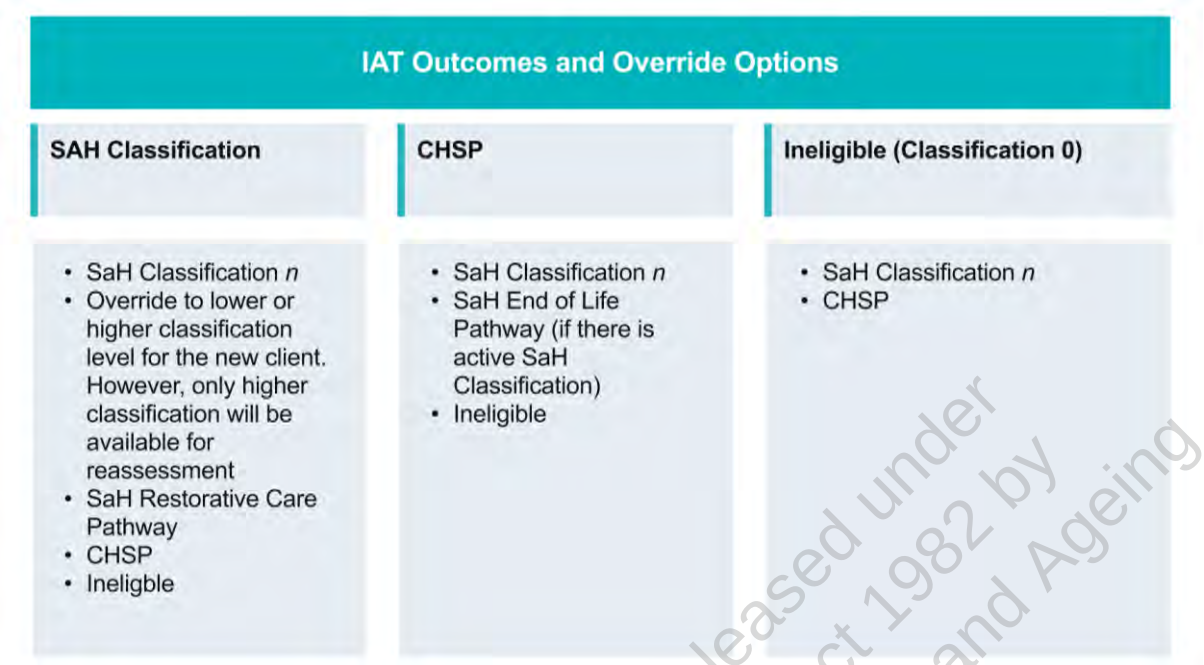
Accepting the IAT Outcome

If the assessor accepts the IAT outcome, they can manually add other additional recommendations, where eligible. All other service recommendations will not be generated by the automated IAT outcome and can be selected manually by the assessor.

While the assessment is in progress, the assessor will be able to edit the classification and services prior to submitting for delegate approval.

An outcome of *Ineligible* (classification 0) means the client is ineligible for Support at Home and CHSP, which would mean the client does not have care needs and is likely to not be eligible for residential care.

Overriding the IAT Outcome



IAT Outcomes and Override Options		
SAH Classification	**CHSP**	**Ineligible (Classification 0)**
• SaH Classification *n* • Override to lower or higher classification level for the new client. However, only higher classification will be available for reassessment • SaH Restorative Care Pathway • CHSP • Ineligble	• SaH Classification *n* • SaH End of Life Pathway (if there is active SaH Classification) • Ineligible	• SaH Classification *n* • CHSP

If you override the IAT outcome a screen will display where you can:

- select the Support at Home Classification you recommend the older person is assigned
    - for an individual who is currently not part of the aged care system and is going through their first assessment, the assessor can override the recommended classification level either down (e.g. SAH classification 3 to SAH classification 2) or up (e.g. SAH classification 3 to SAH classification 4)
    - for an existing aged care client going through a new assessment, the classification level must be equivalent or higher in terms of the associated annual funding amount
- recommend the older person is ineligible to receive CHSP or Support at Home services
- recommend the older person for the Support at Home Restorative Care Pathway or the Support at Home End-of-Life Pathway – these pathways can *only* be recommended through the override button if the client is eligible for Support at Home
- recommend the older person for CHSP

If you choose to override the IAT outcome, you will be required to:

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

Depending on the action you take, you will be navigated to the ‘Add Home Support services’ page or ‘Goals & recommendations’ page.

Recommending service types and services

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 access ongoing Support at Home, Restorative Care Pathway or End-of-life Pathway by accepting or overriding the IAT outcome, you 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. For example, under the *Domestic Assistance* service type, 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 those services.

On this page, you can also:

- recommend the frequency and intensity of these 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.

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.

Important: 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 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.