

Assessor Portal User Guide 7 - Completing a Support Plan and Support Plan Review

This user guide is intended for aged care needs assessors who complete a support plan and/or a Support Plan Review, using the My Aged Care assessor portal.

- ! Starting from 1 November 2025, the *Aged Care Act 2024* and the Support at Home program came into effect with significant change to support plans in the IAT.
- To ensure the right IAT is used, and triage can continue for priority referrals, any assessments in the following statuses already started prior to 1 November 2025 and in progress on 1 November 2025 must be restarted:
- Triage complete, main assessment not started
 - Triage complete, main assessment in progress (includes incomplete support plan)
 - Main assessment completed, awaiting delegate decision (comprehensive assessments)

For information on the **Restart Assessment Process**, please refer to Management of active assessments for 1 November 2025 transition – Standard Operating Procedure and Restarting In Progress Assessments for Support at Home (instructional video).

This is available from your Assessment Organisation.

- ! Starting from 1 November 2025, there are changes to assessment delegations under the *Aged Care Act 2024*, for both Clinical and Non-clinical Assessment Delegates.

To understand **Assessment Delegate changes**, refer to 'Chapter 7: Delegations and Approvals under the Act' of [My Aged Care Assessment Manual](#).

For CHSP only: From 29 June 2026, Home Support assessments will require delegate approval in the system, following the same process as comprehensive assessments.

Manual Delegate Approval is no longer required for Home Support assessments.

Assessors should now follow the standard system-based delegate approval process, consistent with comprehensive assessments.

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The Support Plan

The aged care client's support plan records and identifies the client's:

- areas of concern regarding care
- goals to address these concerns
- any recommendations for services or actions to achieve the identified goals.

The client develops their own support plan with an assessor during the face-to-face assessment.

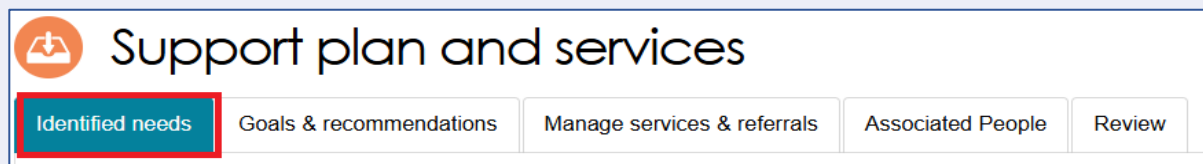
The **SUPPORT PLAN** is made up of several components (tabs):

- Identified Needs
 - Goals & Recommendations
 - Manage Services & referrals
- (Refer to [My Aged Care – Assessor Portal User Guide 8 – Referring for services](#))
- Associated People – showing people associated with the support plan.
 - Review – showing a future to review the support plan.

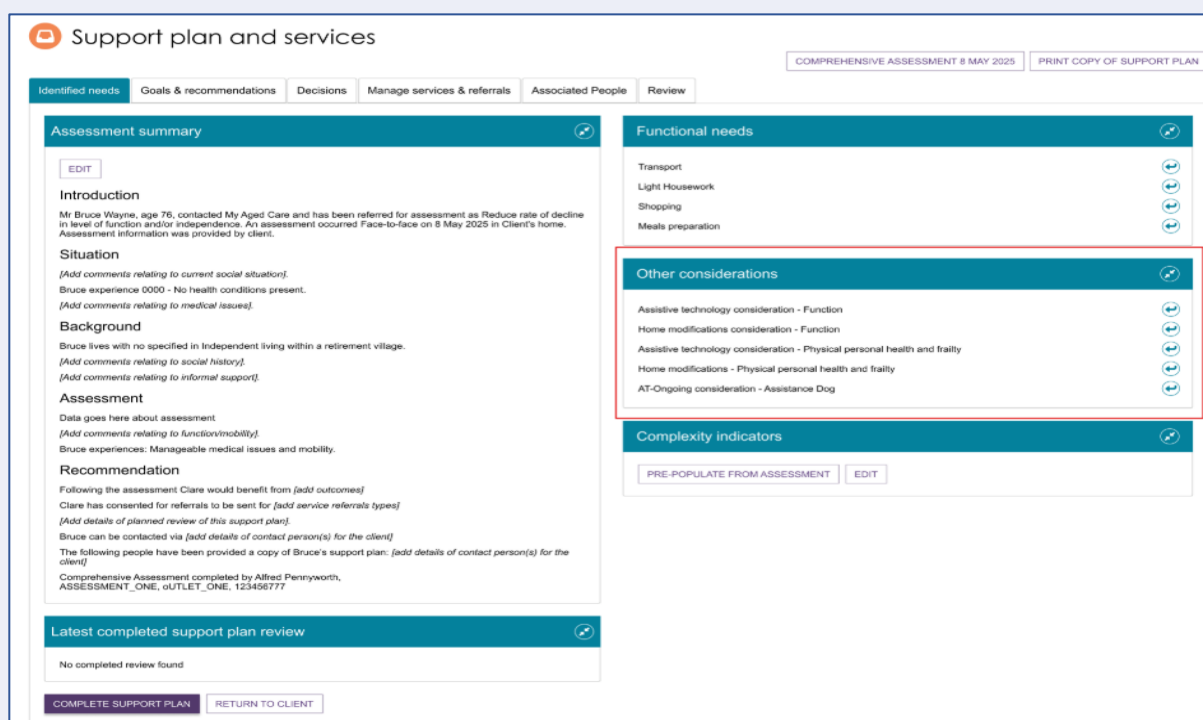
This guide will go into the Goals & recommendations tab in detail.

The Identified needs tab

The **IDENTIFIED NEEDS** tab contains a summary of the needs identified as part of the assessment that require addressing in the support plan. This also includes information of the client's latest completed Support Plan Review if applicable.



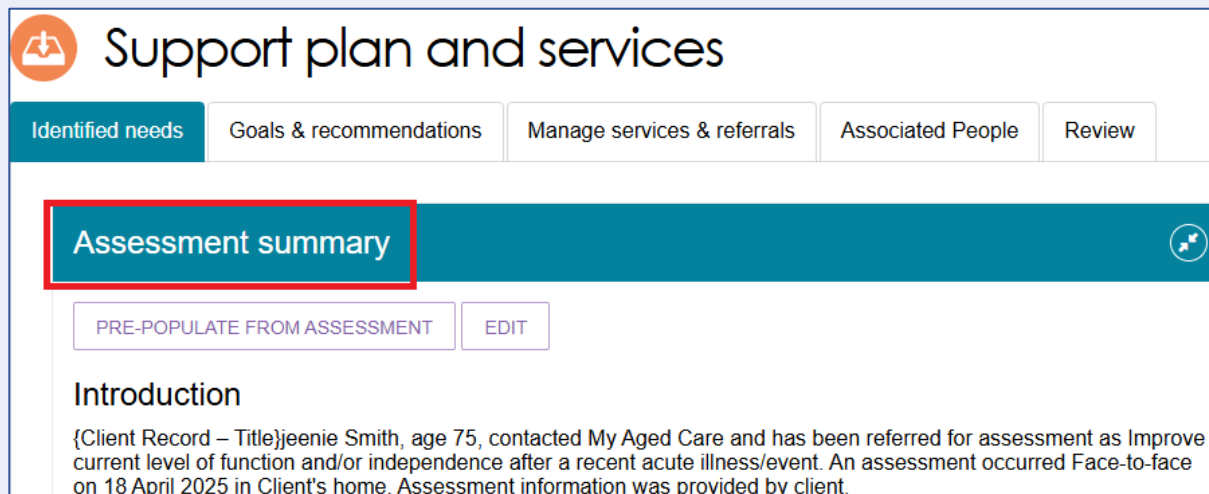
Headings in the Identified Needs tab



Adding an assessment summary

When completing a support plan, assessors can add an **Assessment summary** within the **Identified needs** tab.

The assessor can use **Pre-Populate from Assessment** button to get the assessment summary populated.



Support plan and services

Identified needs | Goals & recommendations | Manage services & referrals | Associated People | Review

Assessment summary

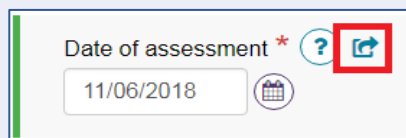
PRE-POPULATE FROM ASSESSMENT | EDIT

Introduction

{Client Record – Title}jeenie Smith, age 75, contacted My Aged Care and has been referred for assessment as Improve current level of function and/or independence after a recent acute illness/event. An assessment occurred Face-to-face on 18 April 2025 in Client's home. Assessment information was provided by client.

This summary appears on the printed support plan provided to the client. It can help conduct further assessments if required. It is visible to service providers who have received a referral for that client.

The assessment summary can be pre-filled based on the information an assessor records in the assessment. An icon (arrow leaving a square pointing right) will display on the fields which automatically pre-fill into the assessment summary.

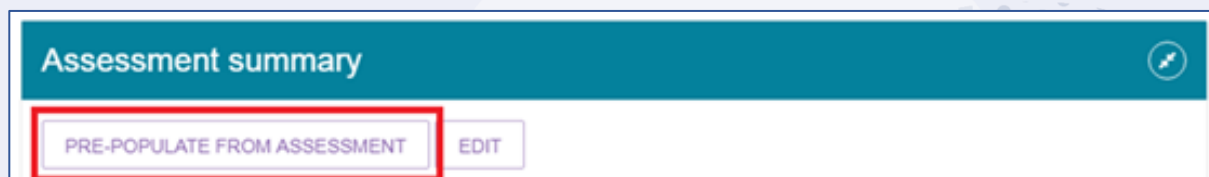


Date of assessment *

11/06/2018

To add an assessment summary based on the information captured from the assessment, select **PRE-POPULATE FROM ASSESSMENT**.

Alternatively, select **EDIT** to edit the assessment summary without any pre-filling. This will open a blank assessment summary.



Assessment summary

PRE-POPULATE FROM ASSESSMENT | EDIT

A read-only view of the assessment summary will display.

The system will populate information where it exists. If information does not exist in a field, the system will advise which field has not been populated. This will display as *[field name]*.

Mrs Jennifer Westbury
Female, 83 years old, 15 September 1941, AC12345678

Primary contact: Jennifer Carl (self) - 06 2222 3333
No support relationships recorded

Support plan and services

You have report(s) that are ready to be downloaded. To download, go to [Reports page](#).

Identified needs | Goals & recommendations | Decisions | Manage services & referrals | Associated People | Review

Assessment summary

PRE-POPULATE FROM ASSESSMENT EDIT

Introduction

Mrs Jennifer age 83, contacted My Aged Care and has been referred for assessment as (Reason for Assessment – Details). An assessment occurred Face-to-face on 9 May 2025 in Client's home. Assessment information was provided by client.

Functional needs

No functional needs found

Other considerations

No other considerations found

Assessors can choose to enter information in the field in the assessment; add relevant information in the assessment summary; or remove the instruction from the assessment summary. Assessors will be prompted to enter additional information that could not be populated from the assessment. This will display as *[example instruction]*.

Support plan and services

Identified needs | Goals & recommendations | Manage services & referrals | Associated People | Review

Assessment summary

PRE-POPULATE FROM ASSESSMENT EDIT

Introduction

{Client Record – Title}jeenie Smith, age 75, contacted My Aged Care and has been referred for assessment as Improve current level of function and/or independence after a recent acute illness/event. An assessment occurred Face-to-face on 18 April 2025 in Client's home. Assessment information was provided by client.

Situation

[Add comments relating to current social situation].
jeenie experiences 0000 - No health conditions present.
[Add comments relating to medical issues].

Background

Select **EDIT** to start editing information in the assessment summary.

Assessment summary

PRE-POPULATE FROM ASSESSMENT **EDIT**

Select **CONFIRM EDIT** to open the editable assessment summary.

Assessment Summary

Once you edit the Assessment Summary and save the changes you have made, you will no longer be able to pre-populate information from the assessment. Select 'Confirm Edit' to continue. Remember to save your changes.

If you want to add additional information into the assessment for it to be pre-populated into the Assessment Summary, select 'Cancel' and return to the assessment.

CONFIRM EDIT CANCEL

Once **CONFIRM EDIT** has been selected and the changes have been saved, the select **Pre-populate from assessment** option will no longer be available to be selected.

Once the assessment summary has been edited/updated, select **SAVE** to save changes. Based on the information pre-populated from the assessment, the assessment summary may exceed the 5000-character limit.

Assessors should reduce the assessment summary by removing or summarising old content.

Assessors can continue to edit the assessment summary after they have saved their changes.

! Ensure changes to the assessment summary are regularly saved, as auto-save does not apply to the assessment summary.

The Goals and recommendations tab

The **Goals & recommendations** tab is where you will record the client's areas of concerns, goals to address their concerns, and any services or general recommendations.

Within the Goals & recommendations tab you will also be able to view the IAT outcome and the recommended classification/s. The recommendation/s is based on inputs from the assessor on the IAT assessment and the client's current care approvals.

If applicable, more than one active approval can be displayed. For example, when a client has an active Restorative Care Pathway (RCP) classification approval, and an SaH 1-8 Classification is approved in a reassessment, both the RCP and the SaH classifications will be shown in the Goals & Recommendations tab.

Accepting the IAT Recommendation

To accept the IAT Outcome, go to the IAT Outcome and Classifications section and select **ACCEPT**.

The screenshot shows the 'Support plan and services' interface. At the top, there are tabs: 'Identified needs', 'Goals & recommendations' (selected), 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. Below the tabs, there are buttons: 'GO TO THE ASSESSMENT', 'FLAG AS END-OF-LIFE', and 'PRINT COPY OF SUPPORT PLAN'. The main section is titled 'IAT Outcome and Classifications'. It displays 'Current assessment type: Comprehensive Assessment' and 'IAT Outcome: SaH Classification 5'. Below this, there are two buttons: 'ACCEPT' (highlighted with a red box) and 'OVERRIDE'.

Overriding the IAT Recommendation

Refer to the other sections in this guide for [Overriding to Restorative Care Pathway](#) and [Overriding to End-of-Life Pathway](#).

! The IAT will allow an ongoing Support at Home Classification to be overridden to a different ongoing classification level.

However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs.

An ongoing SaH classification outcome cannot be overridden to an ongoing lower or higher SaH classification outcome (in line with section 81-10 of the Aged Care Rules).

1. To **OVERRIDE** a recommended classification, select the **OVERRIDE** button located underneath the **IAT Outcome and Classifications** heading.

The screenshot shows the 'Support plan and services' interface. At the top, there are tabs: 'Identified needs', 'Goals & recommendations' (selected), 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. Below the tabs, there are buttons: 'GO TO THE ASSESSMENT', 'FLAG AS END-OF-LIFE', and 'PRINT COPY OF SUPPORT PLAN'. The main section is titled 'IAT Outcome and Classifications'. It displays 'Current assessment type: Comprehensive Assessment' and 'IAT Outcome: SaH Classification 5'. Below this, there are two buttons: 'ACCEPT' and 'OVERRIDE' (highlighted with a red box).

2. The **Override IAT Outcome** pop up appears, prompting the assessor to input the new classification, the override reason and the override reason description.

The list of classifications that are allowed to be selected will depend on the initial IAT Outcome. Assessors are also only allowed to select classifications in line with the Aged Care Rules. Refer to the [My Aged Care Assessment Manual](#) for further information.

The appearance of the pop up and the drop-down options will depend on the original IAT outcome and the intended override.

Below is an example of an Override IAT outcome pop up.

3. If you are overriding to any other classification other than 'Restorative Care Pathway', then you will also need to choose a reason from the 'RCP reject reason' drop down.

(Otherwise, refer to the [Overriding to Restorative Care Pathway](#) section).

The options are: Not suitable/eligible for RCP, Seeking ongoing services, and Other.

If Other was chosen, then you must also enter a description for the reject reason.

4. If you have chosen a Support at Home classification for the override, then you will be asked to select the client's preference for seeking Home support services through the Support at Home program. Select 'Seeking services' or 'Not seeking services'.

An information banner may appear to remind you that 'The client's preference for seeking Home support services determines whether they are in the Support at Home priority system'.

5. Select **SAVE TO PLAN**, **OVERRIDE** or **ACCEPT** once the fields are completed.

Once the classification or recommendation is accepted, a new screen will open to input all the services within each service type available for the classification, their frequency and intensity.

The image below shows an example of the Add Home Support Services page. It shows three services within the Allied Health and Therapy service type available to be chosen.

Add Home Support Services

All fields marked with an asterisk (*) must be completed before submission

Recommended that the client receive: SaH Restorative Care Pathway

Classification Type: Short-term

Please select services within each service type*

Allied health and therapy

Service	Frequency	Intensity
☐ Aboriginal or Torres Strait Islander Health Practitioner assistance		
☐ Aboriginal or Torres Strait Islander Health Worker assistance		
☐ Allied health assistance		

6. Once all the values are entered, Select **SAVE TO PLAN** at the bottom of the page.

The following image shows examples of chosen transport services, with frequency and intensity recorded.

☐ Remedial massage

Transport

Service	Frequency	Intensity
☒ Direct transport	5	Days per week
☒ Indirect transport	10	Time(s) per year

SAVE TO PLAN CANCEL

7. The updated classification will be displayed on the client's **GOALS AND RECOMMENDATIONS** tab.

Support plan and services FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 5
 Recommended classification: SaH Restorative Care Pathway
 Override reason: Has restorative care goals
 Override reason description: reason description goes here

Client concerns and goals
 No client concerns or goals.

Other recommendations

Recommend that the client receive
 Home support

8. The existing classification/s will also display on the right hand side of the updated classification, if applicable.

The below image shows an example of a client with a Transitioned HCP Classification under Support at Home, as per the [Aged Care Act 2024](#).

This is displayed in the Existing Classification section.

Support plan and services REQUEST ASSESSMENT PRINT COPY OF SUPPORT PLAN

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 8
 Existing classification: Transitioned HCP Level 4

The recommendation displays for guidance only. Assessors will still need to select the service the client requires.

For clinical aged care needs assessors (clinical assessors):

- CHSP - refer to *Manual Delegate Approval for CHSP – Standard Operating Procedure* and instructional videos for comprehensive and home support assessments.
- Support at Home Classifications recommendation – refer to [Adding Home Support services](#) for a Support at Home Classification.

For **non-clinical aged care needs assessors** (non-clinical assessors), this means they should consider the following based on the IAT outcome:

- CHSP – refer to *Manual Delegate Approval for CHSP – Standard Operating Procedure* and instructional videos for comprehensive and home support assessments.
- Support at Home – you should consider converting the assessment to a comprehensive assessment under the supervision of a staff member who holds a clinical assessor role.

Types of Recommendations

There are seven types of recommendations that can be added or removed to a support plan following an assessment:

! For Home Support services under the Support At Home Program, refer to [Adding Home Support services](#) for a Support at Home Classification and [Assistive technology and Home modifications \(AT-HM\) Recommendations](#).

- **General recommendations** are non-Commonwealth funded supports that are identified by the assessor and the client and will be actioned by the client or the assessor rather than a service provider, for example: that the client sees a health practitioner, or that they join a local support group.
- **Service recommendations** are for adding recommendations for services to a clients support plan, such as Commonwealth Home Support Program (CHSP) services.
- **Assistive technology** under Support at Home program.
- **Home modification** under Support at Home program.
- **Recommended long-term living arrangement** is only applicable to comprehensive assessments. It is the most appropriate long-term living situation identified during a comprehensive assessment that can be selected from a list of accommodation settings after discussing the goals with the client and/or their supporter. This can only be recommended after a comprehensive assessment has been completed.
- **Care type for Delegate decision recommendations** are applicable only to comprehensive assessments where CHSP is not recommended. These recommendations relate to care types under the [Aged Care Act 2024](#) (the Act) which require approval by a Delegate.
- **Recommendations for a period of linking support** are for where a client's complex circumstances may be a barrier to accessing aged care services, and providing linking support can assist the client to access various services they require.

Recommendations for a period of reablement are for time-limited interventions that are targeted towards a client's specific goal(s) or desired outcome to adapt to some function loss, or regain confidence and capacity to resume their activities, for example: training in a new skill, modification to a client's home environment or having access to equipment or assistive technology.

Linking Recommendations to Goals

Recommendations can be linked to concerns and goals, or they can be added as an **Other Recommendation**. Further information on linking support and reablement is available in the *My Aged Care Assessment Manual* on the [department's website](#).

Recommendations can be associated to more than one goal. When adding your recommendations you can select one or more goals to associate a recommendation or unlink the recommendation from all goals.

1. You can select the appropriate recommendation from the **Other Recommendations** section of the **Goals & Recommendations** tab. You can then choose to link this recommendation to a relevant goal. If you add a recommendation from the **Other Recommendations** section recommendation will be displayed underneath that heading.

15 RIVERBAR SQ | GLEBE ST, CASTLE HILL, NSW, 2124

No support relationships recorded

Concern: Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning

ADD A GOAL

Goal: To be able to perform household tasks

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT | ADD A CARE TYPE FOR DELEGATE DECISION

ADD 'NO CARE TYPE UNDER THE ACT' | RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive **Home maintenance and repairs** 9 May 2025

Recommend that the client receive **Transport** 9 May 2025

Recommend that the client receive **Home Support**

Recommend that the client receive **Home Modifications**

2. Alternatively, you can add a recommendation directly to an area of concern and goal by selecting the arrow next to **Goal** and below **Add to this goal** on the right-hand side of the panel.

If you add a recommendation from the **Add to this goal** section, the recommendation will be displayed underneath the goal.

Select the arrow to the left of the goal to display the recommendation details.

Goal: To be able to perform household tasks

Most relevant domain that goal area relates to:

- Physical function
- General health
- Personal health
- Home and personal safety

Client's current strengths and abilities in relation to this goal:

Can sit and stand up without help for sometime

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:

Difficulty with mobility

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)

Motivation to achieve: 8

Status: In Progress

Recommendations

Recommend that the client receive **Client Care Coordination** 9 May 2025

Recommend that the client receive **Domestic assistance**

Recommend that the client receive **Home maintenance and repairs** 9 May 2025

Recommendation

Exercise twice per week

Responsibility to action: Client

Recommended by: Sam Myers

Add to this goal:

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT | ADD A CARE TYPE FOR DELEGATE DECISION

[LINK TO THE EXISTING PLAN RECOMMENDATIONS](#)

3. To unlink a recommendation from the goal, select the EDIT icon (Blue Pencil) next to the recommended service under the goal and press the **UNLINK THIS RECOMMENDATION FROM ALL GOALS** button and select **SAVE TO PLAN**.

Edit service recommendation

Priority and dates

Priority *
Medium

Recommended service frequency ? Recommended service intensity ?

Recommend a start date
☐ Yes ☒ No

Recommend a review date
☐ Yes ☒ No

Recommend an end date
☐ Yes ☒ No

Responsibility to action
☒ Assessor ☐ Client ☐ Other

Comments:

0 / 100

Associated goals
☒ To be able to perform household tasks

UNLINK THIS RECOMMENDATION FROM ALL GOALS

SAVE TO PLAN CANCEL

Viewing the Recommendation after a delegate decision

Once the goals and recommendations have been entered, the assessor forwards the referral to the delegate for decision-making. After the delegate completes their review, the assessor can view the outcome, including which recommended services were approved or modified. The assessor can also see if the delegate has added any new services.

To access this information, the assessor can locate the client using the [Find a Client](#) link in the Assessor Portal.

Assessor Portal

My Dashboard Find a client Assessment referrals

You can search for a client in the My Aged Care Assessor Portal by entering their **First Name**, **Last Name**, or **Aged Care User ID** in the search fields.

If the client was recently accessed, you can also select them directly from the **Recently Viewed Persons** section for quicker access.

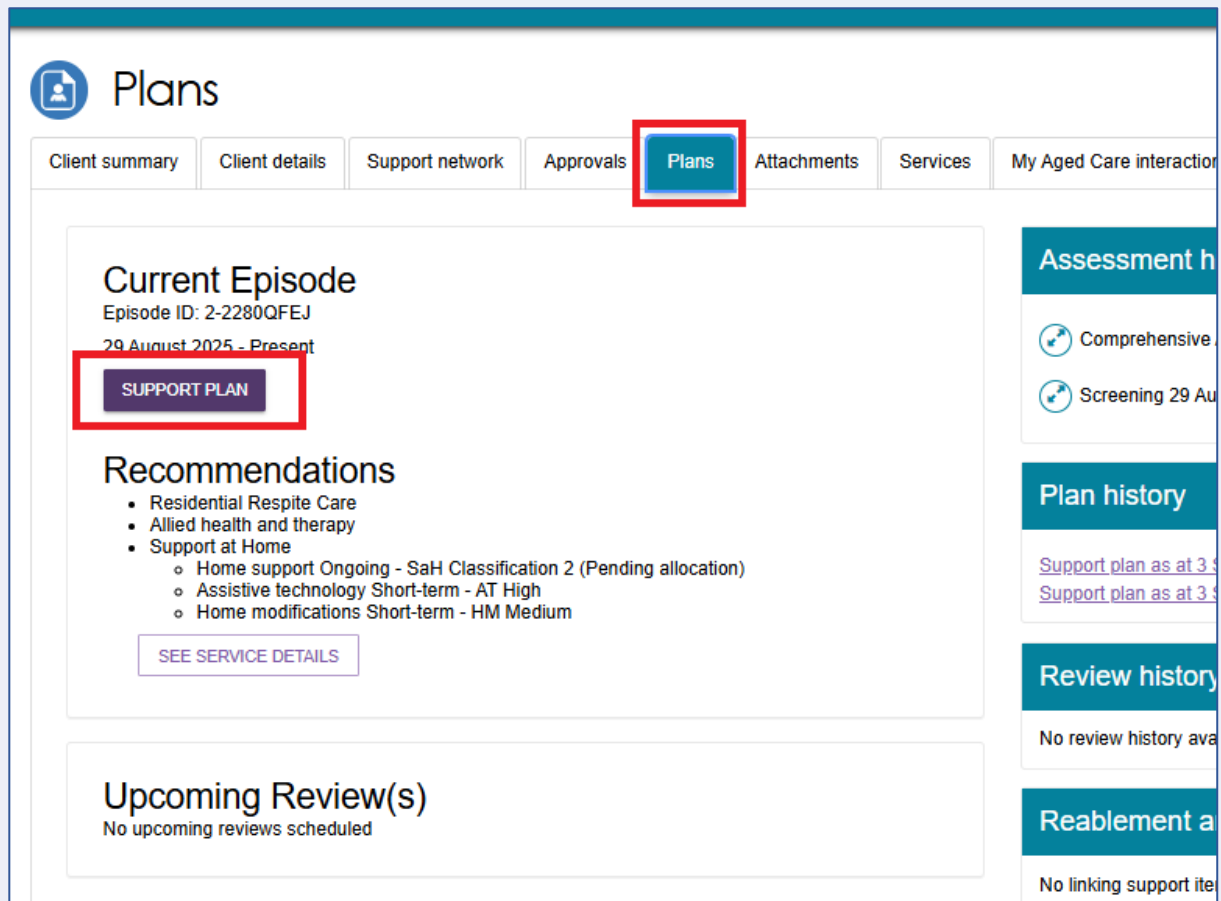
Find a client

Search by

Last name First name Aged Care user ID

Recently Viewed Persons

Once you are in the client record, navigate to the **Plans** tab and select **Support Plan**.



Plans

Client summary | Client details | Support network | Approvals | **Plans** | Attachments | Services | My Aged Care interaction

Current Episode
Episode ID: 2-2280QFEJ
29 August 2025 - Present

SUPPORT PLAN

Recommendations

- Residential Respite Care
- Allied health and therapy
- Support at Home
 - Home support Ongoing - SaH Classification 2 (Pending allocation)
 - Assistive technology Short-term - AT High
 - Home modifications Short-term - HM Medium

[SEE SERVICE DETAILS](#)

Upcoming Review(s)
No upcoming reviews scheduled

Assessment history

- Comprehensive
- Screening 29 Aug

Plan history

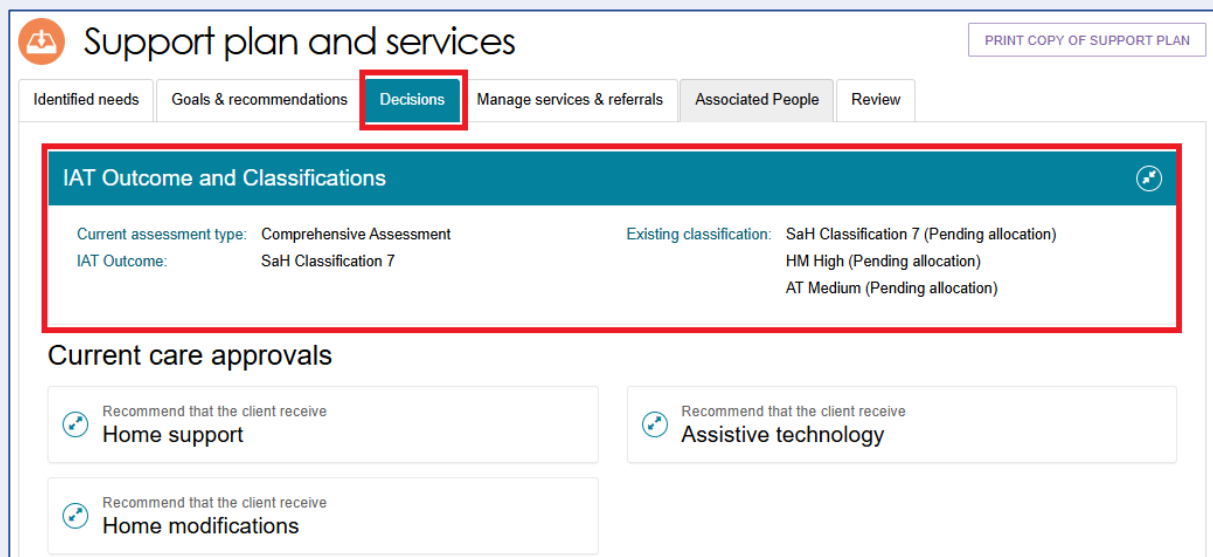
- [Support plan as at 3 Sep](#)
- [Support plan as at 3 Sep](#)

Review history
No review history available

Reablement and support
No linking support items

Once you are in the client's **Support Plan and Services** screen within the Assessor Portal, navigate to the **Decisions** tab to view the delegate's decision.

This section displays the outcome of the delegate's review, including any approved, modified, or newly recommended services.



Support plan and services [PRINT COPY OF SUPPORT PLAN](#)

Identified needs | Goals & recommendations | **Decisions** | Manage services & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
Existing classification: SaH Classification 7 (Pending allocation)
HM High (Pending allocation)
AT Medium (Pending allocation)
IAT Outcome: SaH Classification 7

Current care approvals

- Recommend that the client receive Home support
- Recommend that the client receive Assistive technology
- Recommend that the client receive Home modifications

Scroll down to the **Delegate Decisions and Comments** section within the **Decisions** tab to view all decisions made by the delegate regarding the services recommended for the client.

This area provides a detailed summary of approved, modified, or newly suggested services, along with any comments or justifications provided by the delegate.

Delegate decisions and comments

Assessment: Submitted on 29 January 2026

Decisions



Recommend that the client receive

Home support

Classification: SaH Classification 7

Classification type: Ongoing

Home support services: **Care management:** Home support care management
Domestic assistance: General house cleaning, Laundry services, Shopping assistance
Home maintenance and repairs: Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
Home or community general respite: Community and centre-based respite, Flexible respite
Meals: Meal delivery, Meal preparation
Nursing care: Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
Nutrition: Nutrition supports
Personal care: Assistance with self-administration of medications, Assistance with self-care and activities of daily living, Continence management (non-clinical)
Social support and community engagement: Accompanied activities, Assistance to maintain personal affairs, Cultural support, Digital education and support, Expenses to maintain personal affairs, Group social support, Individual social support
Transport: Direct transport, Indirect transport

Approval start: 29 January 2026

Agreed



Recommend that the client receive

Assistive technology

Assistive technology tier: AT Medium

Classification type: Short-term

Assistive technology services: **Equipment and products:** Assistive technology prescription and clinical support, Communication and information management products, Domestic life products, Managing body functions, Mobility products, Self-care products

Approval start: 29 January 2026

Cease date: 23 April 2027

Agreed



Recommend that the client receive

Home modifications

Home modifications tier: HM High

Classification type: Short-term

Home modifications services: **Home adjustments:** Home modification products, Home modifications prescription and clinical support

Approval start: 29 January 2026

Cease date: 23 April 2027

Agreed

Decision date (Assessment)

29 January 2026 04:14 PM (Australian Eastern Standard Time)

Adding Recommendations

To add a general recommendation, go to [General Recommendation](#).

To add a service recommendation, go to [Service Recommendation](#).

To add a Home modification, go to [Adding a Home modification Recommendation](#).

To add an Assistive technology Service, go to [Adding Assistive technology Recommendation](#).

To add a recommendation for a period of linking support, go to [Period of Linking Support](#).

To add a recommendation for a period of reablement, go to [Period of Reablement](#).

To add a recommendation for a Care type for Delegate decision, go to [Care type for Delegate decision](#).

To add a recommendation of No Care Type Under the Act, go to [No Care Type Under the Act](#).

To add a recommendation for No Care Approval or for No Change to Existing Care Approvals, go to [No Care Approval/No Change to Existing Care Approvals](#).

General Recommendation

Select Add a general recommendation.

Examples of general recommendations include:

- Develop Emergency Care Plan.
 - Connect with GP or other health professional.
 - Gain assistance with decision making.
 - Obtain a smoke alarm.
 - Develop a Personal Emergency Plan.
 - Investigate getting a Personal Alarm.
1. When a pop-up box is displayed, enter information about the general recommendation, check the box if you are linking it to a goal and select **SAVE TO PLAN**.

As assessors are completing the assessment, they will be able to add general recommendations to the support plan from the assessment.

2. In the assessment, the assessor can select to **Add as Recommendation** and this will populate in the **Identified needs** and **Goals & recommendations** tabs in the support plan.

Service Recommendation

Select **Add a service recommendation**.

When a pop-up box is displayed, select the recommended service, complete all mandatory fields and select **SAVE TO PLAN**.

For more information on Support at Home Assistive technology services and Home modification services, refer to the [Support at Home - Assistive technology and Home modifications \(AT-HM\) Recommendations](#) section.

The priority for Support at Home service recommendations will default to the priority as calculated by the Integrated Assessment Tool.

Assessors should use the comments field to clarify the specific scope of the services that are recommended to be delivered within the Support at Home service type.

The scope of services should be linked to the identified needs from the assessment and goals referred to in the support plan, for example: unable to get to places beyond walking distance; requires transport to health clinic.

! Transitioned Clients from MPS or NATSIFAC Program

Assessors can select **Services under the MPSP** and **Services under the NATSIFACP** as a Service Recommendation.

Transitioned clients are identified by the phrase **MPSP NATSIFACP Deeming** in the client summary page, and the Goals and Recommendations tab of the client record.



There will also be an information message reminding assessors that Client is approved to access services through a provider under MPSP or NATSIFACP.



No Care Type Under the Act

Use **No Care Type Under the Act** when a client has withdrawn their application for care under the *Aged Care Act*. This outcome does not require delegate approval. This option will display before accepting or overriding the IAT outcome.

! This option will not appear if the Integrated Assessment Tool (IAT) algorithm recommends Support At Home (SaH) or CHSP classification and you accepted.

1. Select 'Add No Care Type Under the Act'.

This image shows an example where 'Add No Care Type Under the Act' is the only recommendation available to be selected (all other recommendations are greyed out) prior to accepting or overriding the IAT outcome.

- When a pop-up box is displayed, select the reason for the recommendation that the client receives No Care Type Under the Act, enter a comment or reason if appropriate and select **SAVE TO PLAN**.

No care type under the Act

Warning: You have selected this option because the client has withdrawn their application for care under the Act. This assessment will not be submitted to the Delegate for a Decision.

All fields marked with an asterisk (*) are required.

Reason: *
Client withdrew application

Reason or comments (optional)
Maximum 255 characters

0 / 255

SAVE TO PLAN **CANCEL**

- Alternatively, if you add a recommendation from the **Other recommendations** section or are adding a **No Care Type Under the Act** recommendation, the recommendation will be displayed underneath that heading. The recommendation will not be linked to a goal.

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT | RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
'No care type under the Act'

There are no service recommendations for this client

COMPLETE SUPPORT PLAN **RETURN TO CLIENT**

✓ A recommendation for No care type under the Act has been added to the support plan.

No Care Approval/No Change to Existing Care Approvals

No Care Approval and No Change to Existing Care Approvals are two special types of [care type for Delegate Decision](#).

Comprehensive assessors and Home support assessors can add either No Care Approval or No Change to Existing Care Approvals to an IAT assessment, then submit the assessment for delegate approval before finalising the support plan.

However, these options are not available during the support period or the support plan review.

Use **No Care Approval** when the client has no previous approval records, has been assessed, but no services or care approvals are recommended because the IAT outcome shows the client is not eligible for CHSP or SaH based on their assessed needs. This IAT outcome must be accepted prior to selecting the option.

Use **No Change to Existing Care Approvals** during a reassessment where the outcome does not change the client's existing approvals. This outcome also requires delegate approval. This option appears if the client has previous approval records.

Follow these steps to add No Care Approval or No Change to Existing Care Approvals:

1. Select either **NO CARE APPROVAL**, or **NO CHANGE TO EXISTING CARE APPROVALS**, from the Other Recommendations section.

No Care Approval example

The screenshot shows the 'Support plan and services' interface. The 'Goals & recommendations' tab is active. Under 'IAT Outcome and Classifications', the 'Current assessment type' is 'Home Support Assessment', and both 'IAT Outcome' and 'Recommended classification' are 'Ineligible for CHSP/SaH'. In the 'Other recommendations' section, the 'ADD NO CARE APPROVAL' button is highlighted with a red box. Below this section, it states 'There are no service recommendations for this client'.

No Change to Existing Care Approvals example

The screenshot shows the 'Support plan and services' interface. The 'Goals & recommendations' tab is active. Under 'IAT Outcome and Classifications', the 'Current assessment type' is 'Comprehensive Assessment', 'Existing classification' is 'CHSP', and both 'IAT Outcome' and 'Recommended classification' are 'CHSP'. In the 'Other recommendations' section, the 'ADD NO CHANGE TO EXISTING CARE APPROVALS' button is highlighted with a red box.

These options are also available directly from a client's goal. The below image shows an example of adding No Care Approval in the Client Concerns and Goals section.

Client concerns and goals

ADD AREA OF CONCERN

Concern:
Mobility within the home

ADD A GOAL

Goal: To get around their home easily without as much assistance

Most relevant domain that goal area relates to:
• Physical function

Client's current strengths and abilities in relation to this goal:
Info here

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Info here

Support the client's carer provide to achieve this goal:
Info here

Focus of the goal for the client:
• To regain a function (e.g can be physical, cognitive or social)

Motivation to achieve: 1

Status: In Progress

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION RECOMMEND A PERIOD OF LINKING SUPPORT RECOMMEND A PERIOD OF REABLEMENT

LINK TO AN EXISTING RECOMMENDATION **ADD NO CARE APPROVAL**

2. Optionally, enter your reason or comments in the pop up, then select **SAVE TO PLAN**.

No Care Approval example

Add no care approval

All fields marked with an asterisk (*) are required.

Reason or comments

0 / 255

SAVE TO PLAN CANCEL

No Change to Existing Care Approvals example

Add no change to existing care approvals

Reason or comments

0 / 255

SAVE TO PLAN CANCEL

3. The recommendation appears in the client's Goals & Recommendations section of the support plan, along with a success banner 'Your recommendation has been added'.
Delegate decision is then required.

No Care Approval example

 Recommend that the client receive

23 July 2026  

No Care Approval

(not yet in place)

 **This recommendation requires a delegate decision**

Priority for this care type: Low

Recommended by: Oni Traversi (Assessor) Grand Willow Health

COMPLETE SUPPORT PLAN

RETURN TO CLIENT

 Your recommendation has been added

No Change to Existing Care Approvals example

 Recommend that the client receive

23 July 2026  

No Change to Existing Care Approvals

(not yet in place)

 **This recommendation requires a delegate decision**

Priority for this care type: Low

Recommended by: Obi Traversi (Assessor) Grand Willow Health

COMPLETE SUPPORT PLAN

RETURN TO CLIENT

 Your recommendation has been added

! *CHSP, MPSP or NATSIFAC in the support plan*

If a client already has a CHSP, MPSP or NATSIFAC recommendation (including CHSP services added as 'urgent') in their support plan, assessors can complete the client's support plan for a Comprehensive assessment, without needing to add the following recommendations:

- Add a care type for delegate decision, or
- No care approval, or
- No change to existing care approvals.

Otherwise, an error message will appear:

 No Care Approval' or 'No Change to Existing Care Approvals' cannot be added when CHSP/MPS/NATSIFAC service has been recommended.

Period of Linking Support

Select **RECOMMEND A PERIOD OF LINKING SUPPORT**. In the pop-up box that will display, enter the start date for the period of linking support and the recommended end date, and select the reason for recommending linking support from the drop-down menu. Include any relevant comments and linking to any goals where applicable. Select **RECOMMEND** saving to the client's support plan.

During a period of linking support, extension requests for Transition Care and Residential Respite Care services can be requested and granted. Further information regarding linking support is available in the [My Aged Care Assessment Manual](#).

Recommend a period of linking support

All fields marked with an asterisk (*) are required.

What is linking support ?

Start date *

25/05/2018

Recommended end date *

(e.g. dd/mm/yyyy)

Reason for linking support period *

Short term assistance to access aged care services

Comments

Associated goals

☒ To be mobile enough to enjoy gardening and outdoor activities again.

☐ To get eyes checked and new prescription glasses.

[UNLINK THIS RECOMMENDATION FROM ALL GOALS](#)

0 / 500

RECOMMEND

CANCEL

Period of Reablement

Select **RECOMMEND A PERIOD OF REABLEMENT**. When a pop-up box is displayed, enter the start date for the period of reablement and the recommended end date, and select the reason for recommending reablement from the drop-down menu. Enter any relevant comments and linking to any goals where applicable. Select **RECOMMEND** saving to the clients support plan.

During a period of reablement, extensions requests for Transition Care and Residential Respite Care services can be requested and granted.

Further information regarding reablement is available in the [My Aged Care Assessment Manual](#).

Recommend a period of reablement

All fields marked with an asterisk (*) are required.

What is reablement ?

Start date *

09/02/2023

RecommendedEndDate: *

28/02/2023

Reason for reablement period *

To supporting independence through assessment for appropriate aids and equipment

Comments

Comments go here

16 / 500

RECOMMEND

CANCEL



Care type for Delegate decision

1. Select **ADD A CARE TYPE FOR DELEGATE DECISION**. This can be done either as part of a goal, or separately.

ADDING A CARE TYPE AS PART OF A GOAL

Goal: To be able to perform their household tasks

Most relevant domain that goal area relates to:

- Physical function
- Home and personal safety

Client's current strengths and abilities in relation to this goal:
Able to move so can perform some duties

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Issue with physical health

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)
- To receive care for a lost or declining function (e.g. can be physical, cognitive or social)

Motivation to achieve: 8

Status: In Progress

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD AN ASSISTIVE TECHNOLOGY ADD A HOME MODIFICATION RECOMMEND A PERIOD OF LINKING SUPPORT

RECOMMEND A PERIOD OF REABLEMENT **ADD A CARE TYPE FOR DELEGATE DECISION** LINK TO AN EXISTING RECOMMENDATION LINK TO THE EXISTING SAH RECOMMENDATIONS

ADDING A CARE TYPE SEPARATELY

Client concerns and goals

ADD AREA OF CONCERN

Concern: Unable to perform certain household duties

ADD A GOAL

Goal: To be able to perform their household tasks

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD AN ASSISTIVE TECHNOLOGY ADD A HOME MODIFICATION ADD RECOMMENDED LONG TERM LIVING

ADD A CARE TYPE FOR DELEGATE DECISION ADD 'NO CARE TYPE UNDER THE ACT' RECOMMEND A PERIOD OF LINKING SUPPORT RECOMMEND A PERIOD OF REABLEMENT

2. At the pop-up, select which care type applies, enter the reason and comments, if necessary, then select **SAVE TO PLAN**. The care types available are: Residential permanent, Residential respite care, and Transition Care.

Add care type for delegate decision

All fields marked with an asterisk (*) are required.

Which care type applies? *

Select one

Select one

No Care Approval

Residential Permanent

Residential Respite Care

Transition Care

0 / 255

SAVE TO PLAN CANCEL

! If a client is under the age of 65, several additional entry fields will appear to document their exceptional circumstances.

3. Once the required care type is selected, the pop-up screen will expand asking for further

information. The assessor will be prompted to select the **priority** or **urgency** of the selected care type.

For Residential Permanent and Residential Respite Care, urgency is used.

For Residential Permanent the field is editable and needs to be selected. For Residential Respite Care the field will default to High and cannot be edited.

The Aged Care Assessment manual provides guidance on selecting level of urgency.

For Residential Respite Care, ensure that the DEMMI checkbox is ticked, and a valid reason is entered as shown in the following image.

Add care type for delegate decision

All fields marked with an asterisk (*) are required.

Which care type applies? *
Residential Respite Care

If time-limited, when does the approval stop (optional):
(e.g. dd/mm/yyyy)

What is the urgency of this care type? * ?
High

Is this emergency care?
☐ Yes ☒ No

Reason or comments

☒ I was unable to undertake a modified DEMMI on this client at this assessment and I am required to enter my 'unable to complete' reason in the text box below. I understand that this means that if this client has not previously received a modified DEMMI assessment they will enter the default respite class and will need to have a modified DEMMI assessment completed at a later date. *

Reason DEMMI not completed *
Client has not received a modified DEMMI previously

51 / 500

SAVE TO PLAN CANCEL

4. Select **SAVE TO PLAN**.

- ! If a client's home address is not recorded, you will receive a warning message to update the address while performing the above step.

Add care type for delegate decision

! Please update the client record to record a home address. If the home address is not recorded you will be unable to manually capture the MMM classification. You can proceed with a residential aged care recommendation without capturing a client's home address. However, the home address and MMM classification will not be used to determine the client's priority category.

All fields marked with an asterisk (*) are required.

Which care type applies? *
Residential Respite Care

If time-limited, when does the approval stop (optional):
(e.g. dd/mm/yyyy)

What is the urgency of this care type? * ?
High

Is this emergency care?
☐ Yes ☒ No

SAVE TO PLAN CANCEL

Support at Home Recommendations

Adding Home Support services

Once the clinical assessor has accepted the Support at Home classification, the assessor will be prompted to add Home Support services for the client. For each service that is recommended for the client, you will need to tick the tick box, enter a frequency and an intensity.

! If the assessor does not select a service, the Support at Home service provider will not be permitted to provide the service to the client, which may result in a Support Plan Review to add the service to the Support at Home classification.

When assessing for Support at Home, the Support Plan allows assessors to select all relevant service types when making a recommendation. This minimises the number of Support Plan Reviews raised. The only exception is Allied Health and Therapeutic Services for Independent Living, which must be selected manually based on identified goals.

Home | Assessments | Assessment | Bart SAMPSON support plan and services

Master Bart SAMPSON
Male, 81 years old, 1 March 1944, AC01234567

Primary contact: Bart Sampson (self)
No support relationships recorded

REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT REPORT

Add Home Support services

All fields marked with an asterisk (*) must be completed before submission

Recommended that the client receive: SdH Classification 5
Classification Type: Ongoing

Please select services within each service type*

Home or community general respite

Service	Frequency	Intensity	Goals
☒ Community and centre-based respite	2	Days per month	
☒ Flexible respite	3	Days per week	

Nutrition

Service	Frequency	Intensity	Goals
☒ Nutrition supports	2	Time(s) per day	

Therapeutic services for independent living

Service	Frequency	Intensity	Goals
☐ Art therapy			

The assessor should review all recommended services to ensure that all the services that are required are either selected or deselected. Then, select the **SAVE TO PLAN** button.

Assessor Portal | My Dashboard | Find a client | Assessment referrals | Review requests | Assessments | Reviews | Organisation administration | Residential Funding Referrals | Find a service provider | Reports and documents | Aged Care Assessment app | Tasks and notifications | My Aged Care interactions | Logout

Home | Assessments | Assessment | Bart SAMPSON support plan and services

Master Bart SAMPSON
Male, 81 years old, 1 March 1944, AC91734567

Primary contact: Bart Sampson (self)
No support relationships recorded

☐ Social work		
☐ Speech pathology		
☐ Physiotherapy		
☐ Psychology		
☐ Music therapy		
☒ Diet or nutrition	3	Days per month
☐ Allied health assistance		
☐ Aboriginal or Torres Strait Islander Health Practitioner assistance		
☐ Aboriginal or Torres Strait Islander Health Worker assistance		
☐ Exercise physiology		
☐ Occupational therapy		
☐ Counselling or psychotherapy		

SAVE TO PLAN CANCEL

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myagedcare.gov.au

Once saved to the plan you will be redirected to the **Goals & recommendations** tab with a banner stating that the creation of the services to display will take up to 60 seconds to show.

Support plan and services

GO TO THE ASSESSMENT | FLAG AS END OF LIFE | PRINT COPY OF SUPPORT PLAN

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals | Associated People | Review

i Your request is being processed and may take up to 60 seconds. Once processing finishes you will see the services updated on the screen.

Once expanded, the assessor will be able to view the Support at Home service recommendation/s. Select the **View (magnifying glass) icon** to view them in detail.

Recommend that the client receive
Home Support

6 May 2025

(not yet in place)

This recommendation requires a delegate decision

Classification:
Classification type:
Home Support services:
Recommended by:

SaH Classification 5
Ongoing
Home or community general respite: Community and centre-based respite, Flexible respite
Nutrition: Nutrition supports
Domestic assistance: General house cleaning, Laundry services, Shopping assistance
Home maintenance and repairs: Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
Meals: Meal delivery, Meal preparation
Social support and community engagement: Group social support
Transport: Direct transport, Indirect transport
Care management: Home support care management
Personal care: Assistance with self-administration of medications, Assistance with self-care and activities of daily living, Continence management (non-clinical)
Nursing care: Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
Allied health and therapy: Diet or nutrition
Brenna Hale (Assessor) Sunrise Assessments - ACA - VIC 3

COMPLETE SUPPORT PLAN

RETURN TO CLIENT

The detailed view shows the recommended service with frequency.

Show more by using the **expand** buttons.

To return, select the **CLOSE** button.

Home support services

Classification: SaH Classification 5 Classification Type: Ongoing

☒ Allied health and therapy

- Diet or nutrition: recommended frequency is 3 days per month.

☒ Care management

- Home support care management:

☐ Domestic assistance

☐ Home maintenance and repairs

☐ Home or community general respite

- Community and centre-based respite: recommended frequency is 2 days per month.
- Flexible respite: recommended frequency is 3 days per week.

☐ Meals

☐ Nursing care

☐ Nutrition

CLOSE

Once the assessor has completed all the required changes, select the **COMPLETE SUPPORT PLAN REVIEW**.

Viewing Recommended SaH services

- To view details and the statuses of a client's services recommended under their Support at Home classifications, navigate to **OTHER RECOMMENDATIONS** under the **GOALS AND RECOMMENDATIONS** tab. Select the expand icon next to the service, and then select the blue magnifier (View) icon.

Other recommendations

☐ Recommend that the client receive
Equipment and products 8 May 2025

☒ Recommend that the client receive
Home Support 8 May 2025

(not yet in place)

● **This recommendation requires a delegate decision**

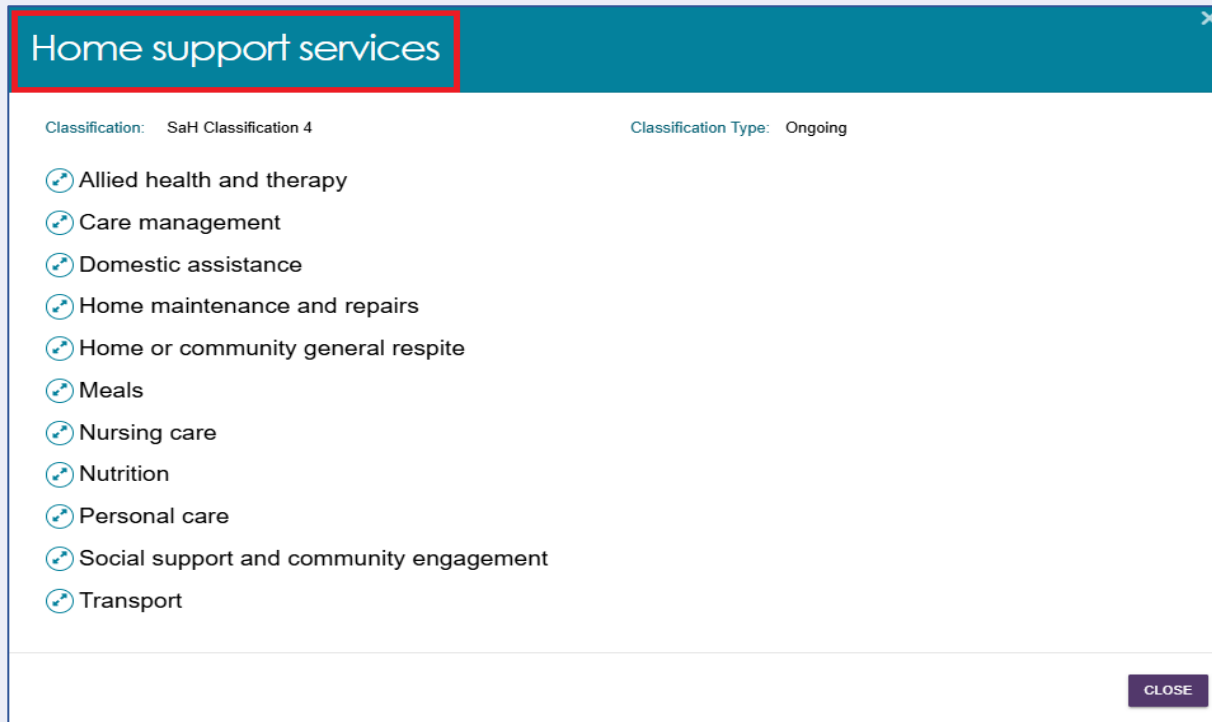
Classification: SaH Classification 4

Classification type: Ongoing

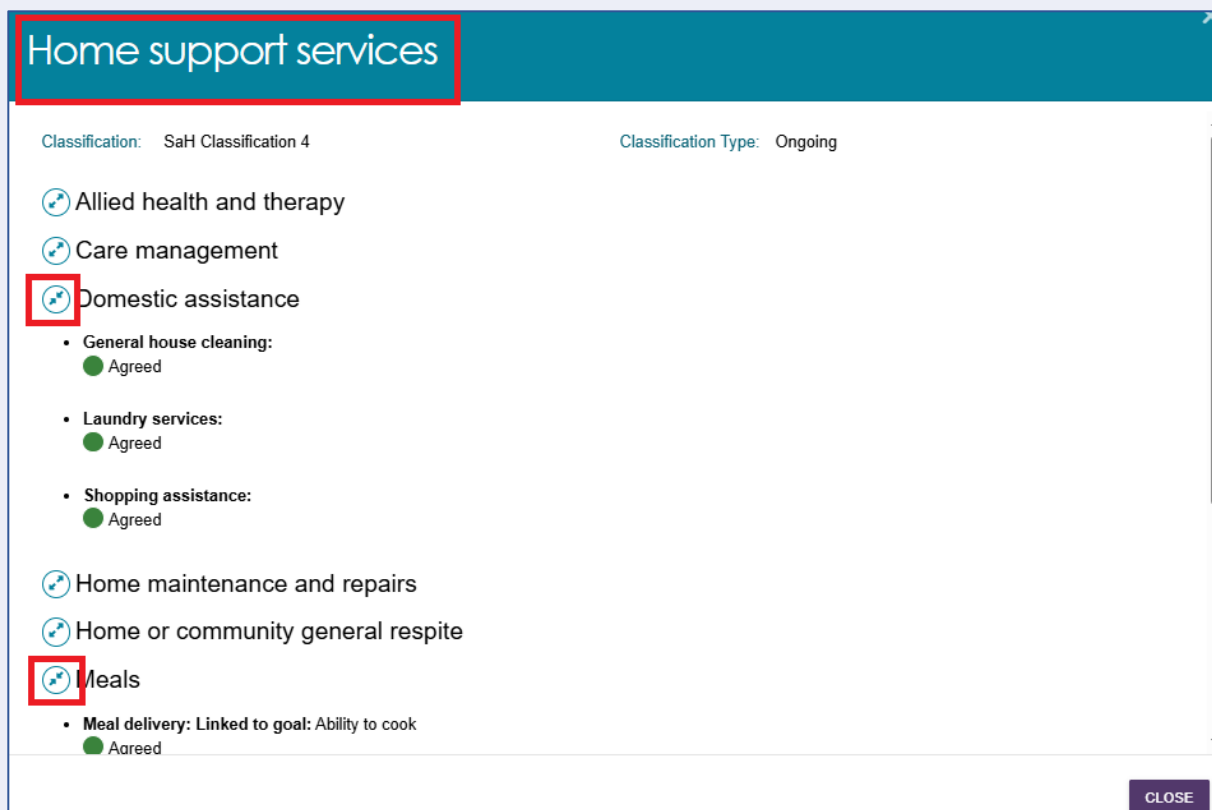
Home Support services:

- Home or community general respite:** Community and centre-based respite, Flexible respite
- Nutrition:** Nutrition supports
- Domestic assistance:** General house cleaning, Laundry services, Shopping assistance
- Home maintenance and repairs:** Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
- Meals:** Meal delivery, Meal preparation
- Social support and community engagement:** Accompanied activities, Assistance to maintain personal affairs, Cultural support, Digital education and support, Expenses to maintain personal affairs, Group social support, Individual social support
- Transport:** Direct transport, Indirect transport
- Care management:** Home support care management
- Personal care:** Assistance with self-administration of medications, Assistance with self-care and activities of daily living, Continence management (non-clinical)
- Nursing care:** Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
- Allied health and therapy:** Diet or nutrition

A Pop-up screen will open listing all the services recommended.



2. Select the expand card icon to view the details and statuses of all the services associated.



Assistive technology and Home modifications (AT-HM) Recommendations

This section outlines how to view, add and edit services offered under the Assistive technology and Home modifications (AT-HM) Services.

Adding a Home modification Recommendation

- ! When considering adding/editing Home modifications care recommendations, refer to:
- *Support Plan* section of [My Aged Care – Integrated Assessment Tool \(IAT\) User Guide](#)
 - *Approving AT and HM under Support at Home and Approving AT and HM under CHSP* sections under Chapter 8 of the [My Aged Care Assessment Manual](#)
 - AT-HM Scheme Guidelines on support plan or support plan reviews for AT-HM. Assessment operation managers have access to the AT-HM tier guide document on the assessor SharePoint site. Operation managers can download and provide the template to assessors.
 - Assessor workforce training.

If the client's IAT outcome is of any Support at Home Classification, the assessor can add a Home modification recommendation during the assessment.

1. Go to the client's **GOALS AND RECOMMENDATIONS** tab within the Support Plan and Services screen.

If **AT/HM Short-term** was selected as an Other Consideration during the IAT, then there will be an information message reminding you to 'please consider the identified needs captured in the Other Considerations section when making an AT or HM funding tier recommendation'.

Support plan and services

GO TO THE ASSESSMENT FLAG AS END OF LIFE COMPREHENSIVE ASSESSMENT 8 MAY 2025 PRINT COPY OF SUPPORT PLAN

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

i Please consider the identified needs captured in the other considerations section when making an AT or HM funding tier recommendation

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT outcome: SaH Classification 3
 Recommended classification: SaH Classification 3 ✓

2. Scroll to the **OTHER RECOMMENDATIONS** section. Select **ADD A HOME MODIFICATION**.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 AT Medium

Override reason: Higher level service needs
 Override reason description: Require higher level of care

Client concerns and goals

[ADD AREA OF CONCERN](#)

No client concerns or goals.

Other recommendations

[ADD A GENERAL RECOMMENDATION](#) [ADD A SERVICE RECOMMENDATION](#) [ADD AN ASSISTIVE TECHNOLOGY](#) **[ADD A HOME MODIFICATION](#)** [ADD RECOMMENDATION](#)

[RECOMMEND A PERIOD OF LINKING SUPPORT](#) [RECOMMEND A PERIOD OF REABLEMENT](#)

3. The **Add Home modifications recommendation** screen will display.

Select the relevant Home modification Tier from the drop down. (available tiers are HM Low, HM Medium, HM High). The **SERVICE TYPE**/s will then be pre-filled. At this stage you can link goals by selecting the Edit button next to 'Linked Goals'.

For the next question 'The client's preference for seeking Home modifications services through the Support at Home program is'; select **Seeking services**.

Then, Select **SAVE TO PLAN**.

Add Home modifications recommendation

All fields marked with an asterisk (*) are required.

Home modifications tier *
 HM Medium

Service Type *
 Home adjustments

☒ Home modification products [Linked goals](#)

☒ Home modifications prescription and clinical support [Linked goals](#)

The client's preference for seeking Home modifications services through the Support at Home program is:*

☒ Seeking services ☐ Not seeking services

[SAVE TO PLAN](#) [CANCEL](#)

4. The Home modification recommendation will then display on the client's **GOALS AND RECOMMENDATION** tab under the **OTHER RECOMMENDATIONS** section.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 AT Medium
 HM Medium
 Override reason: Higher level service needs
 Override reason description: Require higher level of care

Client concerns and goals

[ADD AREA OF CONCERN](#)

No client concerns or goals.

Other recommendations

[ADD A GENERAL RECOMMENDATION](#) [ADD A SERVICE RECOMMENDATION](#) [ADD AN ASSISTIVE TECHNOLOGY](#) [ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT](#) [ADD A CARE TYPE FOR DELEGATE DECISION](#) [ADD 'NO CARE' RECOMMENDATION](#)

[RECOMMEND A PERIOD OF REABLEMENT](#)

Recommend that the client receive **Home Support** 7 May 2025

Recommend that the client receive **Home Modifications**

Recommend that the client receive **Assistive Technology**

Your recommendation has been added.

Viewing Home modification Service Recommendation

- To view the details of the Home modification Service, select the blue expand (pencil) icon next to the Home modification service under the **OTHER RECOMMENDATIONS** section.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 AT Medium
 HM Medium
 Override reason: Higher level service needs
 Override reason description: Require higher level of care

Client concerns and goals

[ADD AREA OF CONCERN](#)

No client concerns or goals.

Other recommendations

[ADD A GENERAL RECOMMENDATION](#) [ADD A SERVICE RECOMMENDATION](#) [ADD AN ASSISTIVE TECHNOLOGY](#) [ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT](#) [ADD A CARE TYPE FOR DELEGATE DECISION](#) [ADD 'NO CARE' RECOMMENDATION](#)

[RECOMMEND A PERIOD OF REABLEMENT](#)

Recommend that the client receive **Home Support** 7 May 2025

Recommend that the client receive **Home Modifications**

- Details about the recommended Home modification Service will be displayed.

Recommend that the client receive **Home Modifications**

(not yet in place)

This recommendation requires a delegate decision

Home Modification Tier: HM Medium
 Classification type: Short-term
 Home Modification services: Home adjustments: Home modification products, Home modifications prescription and clinical support
 Recommended by: UAT.Ford UAT.Lovell (Assessor) Sunrise Assessments - ACA - VIC 3

Editing Home modification Recommendation

1. To edit a Home modification recommendation, select the blue **pencil (edit) icon** on the top right hand corner of the Home modification service.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD AN ASSISTIVE TECHNOLOGY ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT ADD A CARE TYPE FOR DELEGATE DECISION

ADD 'NO CARE TYPE UNDER THE ACT' RECOMMEND A PERIOD OF LINKING SUPPORT RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive Home Support 7 May 2025

Recommend that the client receive Home Modifications 7 May 2025

2. The Editing Home modifications recommendation page displays. Apply the required changes and select **SAVE TO PLAN**.

Editing Home modifications recommendation

To allocate a new tier at the same tier level, select button 'Allocate new tier'. To change tiers or update linked goals for new

All fields marked with an asterisk (*) are required.

Home modifications tier *
HM Medium

Service Type *
Home adjustments

☒ Home modification products Linked goals

☒ Home modifications prescription and clinical support Linked goals

SAVE TO PLAN CANCEL

Adding an Assistive technology Recommendation

- !** When considering adding/editing Assistive technology care recommendations, refer to:
- *Support Plan* section of [My Aged Care – Integrated Assessment Tool \(IAT\) User Guide](#)
 - *Approving AT and HM under Support at Home* and *Approving AT and HM under CHSP* sections under Chapter 8 of the [My Aged Care Assessment Manual](#)
 - AT-HM Scheme Guidelines on support plan or support plan reviews for AT-HM. Assessment operation managers have access to the AT-HM tier guide document on the assessor SharePoint site. Operation managers can download and provide the template to assessors.
 - Assessor workforce training.

If the client's IAT outcome is of any Support at Home Classification, the assessor can add an Assistive technology recommendation during the assessment.

1. Go to the client's **GOALS AND RECOMMENDATIONS** tab within the Support Plan and Services screen.

If **AT/HM Short-term** was selected as an Other Consideration during the IAT, then there will be an information message reminding you to 'please consider the identified needs captured in the Other Considerations section when making an AT or HM funding tier recommendation'.

There may be other information messages to help you make an Assistive technology recommendation:

2. Scroll to the **OTHER RECOMMENDATIONS** section.

Select **ADD AN ASSISTIVE TECHNOLOGY**.

3. The **Add Assistive technology recommendation** screen displays. Select the relevant Classification Type (ongoing or short-term) and the Specified Needs (assistance dogs) or the Assistive technology tier (AT low, AT medium or AT high) from the drop-downs.

Depending on what was chosen (and the client's classification), some service types become automatically filled in and pre-selected.

For the next question 'The client's preference for seeking Home modifications services through the Support at Home program is'; select **Seeking services**.

Select **SAVE TO PLAN**.

! Services don't display the Linked goals if the service recommendations are from a previous assessment.

Add AT recommendation - Ongoing Assistance Dogs

Home | Assessments | John KK READ | John KK READ support plan and services | Assistive technology

Add Assistive technology recommendation

The client's preference for seeking Assistive technology services determines whether they are in the AT-HM Priority System.

All fields marked with an asterisk (*) are required.

Classification type *
Ongoing

Specified needs *
Specified needs - Assistance Dogs

Service Type *
Equipment and products

- ☒ Assistive technology prescription and clinical support
- ☒ Communication and information management products
- ☒ Domestic life products
- ☒ Managing body functions
- ☒ Mobility products
- ☒ Self-care products

Linked goals 
Linked goals 
Linked goals 
Linked goals 
Linked goals 
Linked goals 

The client's preference for seeking Assistive technology services through the Support at Home program is: *

☒ Seeking services ☐ Not seeking services

SAVE TO PLAN CANCEL

Add AT recommendation - Short Term, Medium Tier

Add Assistive technology recommendation

The client's preference for seeking Assistive technology services determines whether they are active in the AT-HM Priority System.

All fields marked with an asterisk (*) are required.

Classification type *
Short-term

Assistive technology tier *
AT Medium

Service Type *
Equipment and products

- ☒ Assistive technology prescription and clinical support
- ☒ Communication and information management products
- ☒ Domestic life products
- ☒ Managing body functions
- ☒ Mobility products
- ☒ Self-care products

The client's preference for seeking Assistive technology services through the Support at Home program is: *

☒ Seeking services ☐ Not seeking services

SAVE TO PLAN CANCEL

Viewing Assistive technology Service recommendation

1. [Once the Assistive technology recommendation is added](#), the changes will be displayed on the Client's **GOALS AND RECOMMENDATIONS** tab under the **OTHER RECOMMENDATIONS** section.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals | Associated People | Review

IAT Outcome and Classifications

Client concerns and goals

ADD AREA OF CONCERN

Concern: Unable to perform certain household duties

ADD A GOAL

Goal: To be able to perform their household tasks

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | ADD RECOM

RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
Home Support

Recommend that the client receive
Assistive Technology

2. To view the Assistive technology Services recommended, select the blue Expand icon next to **ASSISTIVE TECHNOLOGY**.

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | ADD RECOMMENDED LONG TERM

RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
Home Support 7 May 2025

Recommend that the client receive
Assistive Technology 22 April 2025

(not yet in place)

This recommendation requires a delegate decision

Assistive Technology Tier: AT Medium

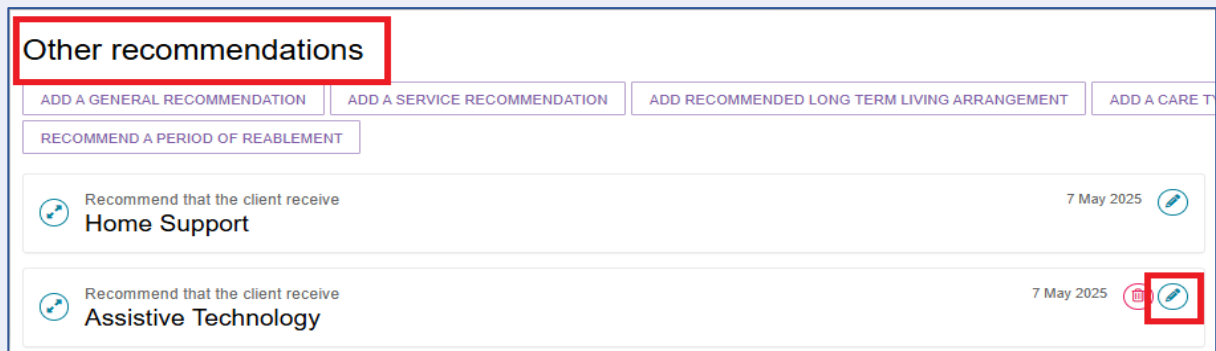
Classification type: Short-term

Assistive Technology services: **Equipment and products:** Assistive technology prescription and clinical support, Communication and information management products, Domestic life products, Managing body functions, Mobility products, Self-care products

Recommended by: UAT.Ford UAT.Lovell (Assessor) Sunrise Assessments - ACA - VIC 3

Editing Assistive technology Recommendation

1. To edit an Assistive technology recommendation, select the blue **Edit (pencil)** icon on the top right hand corner of the Assistive technology service.



Other recommendations

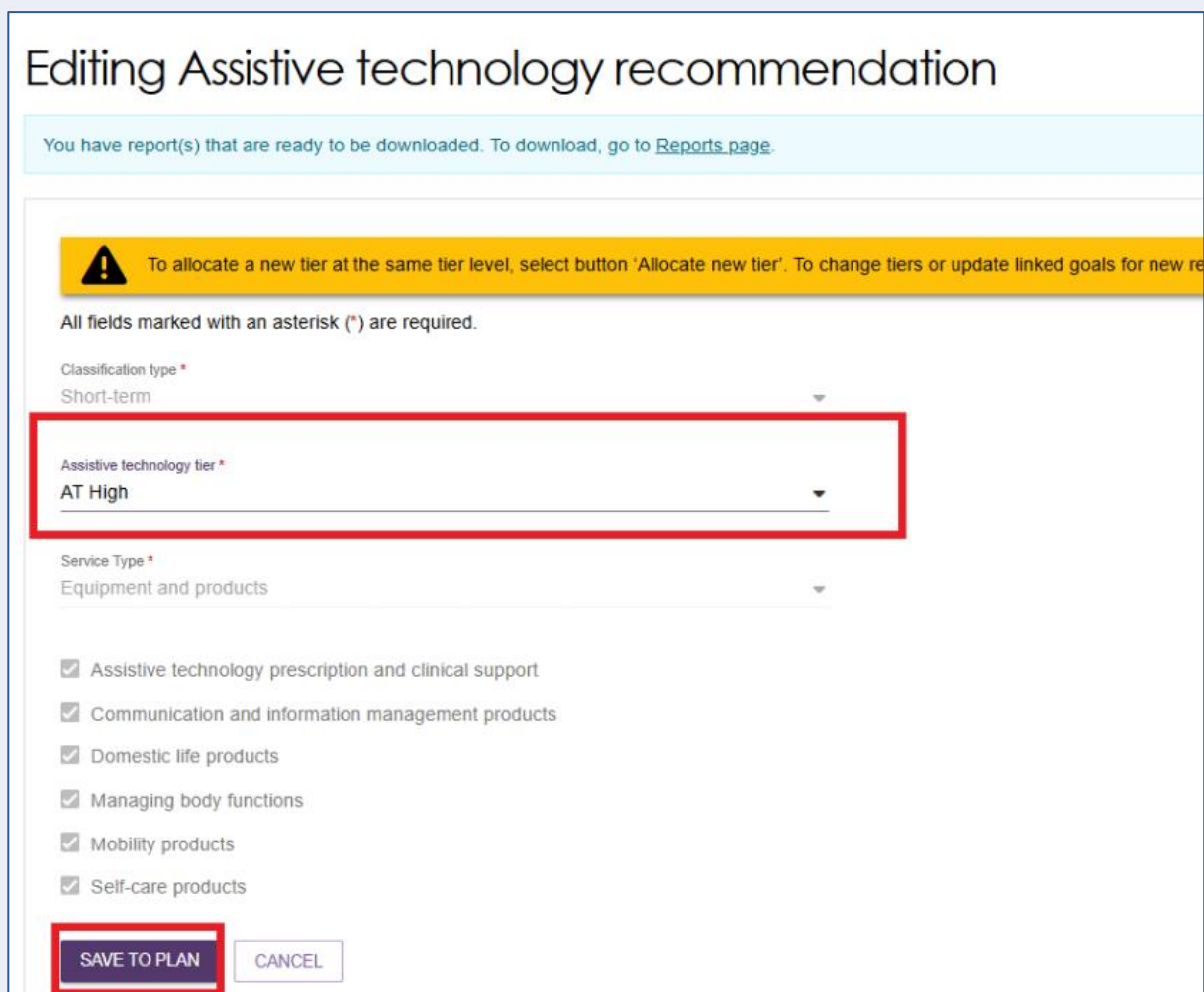
ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT ADD A CARE T

RECOMMEND A PERIOD OF REABLEMENT

Recommend that the client receive
Home Support 7 May 2025

Recommend that the client receive
Assistive Technology 7 May 2025

2. The Editing Assistive technology recommendation page appears. Apply the required changes and select **SAVE TO PLAN**.



Editing Assistive technology recommendation

You have report(s) that are ready to be downloaded. To download, go to [Reports page](#).

! To allocate a new tier at the same tier level, select button 'Allocate new tier'. To change tiers or update linked goals for new re

All fields marked with an asterisk (*) are required.

Classification type *
Short-term

Assistive technology tier *
AT High

Service Type *
Equipment and products

☒ Assistive technology prescription and clinical support
☒ Communication and information management products
☒ Domestic life products
☒ Managing body functions
☒ Mobility products
☒ Self-care products

SAVE TO PLAN CANCEL

Adding Client Concerns and Goals

- From the support plan and services page select the **Goals & recommendations** tab.
Under the Client concerns and goals section, select **ADD AREA OF CONCERN**.

Gender not specified, 56 years old, 25 August 1968, AC01234567
Lot Number 35 1 CELESTE AVENUE CASTLE HILL, NSW, 2154

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
IAT Outcome: SaH Classification 7
Recommended classification: SaH Classification 5 
Override reason: Lower level service needs
Override reason description: Change in care needs

Client concerns and goals

ADD AREA OF CONCERN

- In the pop-up box, record the area of concern, and select **SAVE TO PLAN**.

Add area of concern

Concern:
All fields marked with an asterisk (*) are required.

What is the area of concern? *

Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning

109 / 500

SAVE TO PLAN CANCEL

- The area of concern will appear under the **Client concerns and goals** section.
Select the Bin icon to delete. Select the Pencil icon to edit.

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning  

- To add a goal to the concern, select **ADD A GOAL**.

30 NUMBER 35 T CELES T E AVENUE CASTLE HILL, NSW, 2194

No support relationships recorded

Recommended classification: SaH Classification 5 

Override reason: Lower level service needs

Override reason description: Change in care needs

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty with mobility including performing some household tasks such as laundry, preparing meals, cleaning

ADD A GOAL

In the pop-up box, enter the goal, record the client's motivation to achieve the goal (with 1 being least motivated to 10 being highly motivated), the status of the goal, and select **SAVE TO PLAN**.

This information will appear under the associated area of concern under **CLIENT CONCERNS AND GOALS**.

You can edit or remove goals that may no longer be relevant to the client's situation here, by selecting the **Pencil icon** or **Rubbish bin icon** respectively.

5. Continue to add more concerns and goals by repeating the above step.

! Changing the display order of multiple concerns or goals

When multiple concerns or goals have been added, you are able to change the display order by using the drop-down box at the right-hand side of the record.

- In the **Goals** section, you can add service recommendations that may be relevant to assisting the client in achieving their goals.

Select the blue expand card icon next to the goal where the service needs to be added and select the relevant button.

Refer to [Adding Recommendations](#) for more information.

Goal: To be able to perform household tasks

Most relevant domain that goal area relates to:

- Physical function
- General health
- Personal health
- Home and personal safety

Client's current strengths and abilities in relation to this goal:

Can sit and stand up without help for sometime

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:

Difficulty with mobility

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)

Motivation to achieve: 8

Status: In Progress

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION	ADD A SERVICE RECOMMENDATION	ADD AN ASSISTIVE TECHNOLOGY	ADD A HOME MODIFICATION	RECOMMEND A PERIOD OF LINKING SUPPORT
RECOMMEND A PERIOD OF REABLEMENT	ADD A CARE TYPE FOR DELEGATE DECISION	LINK TO AN EXISTING RECOMMENDATION	LINK TO THE EXISTING SAH RECOMMENDATIONS	

Linking Goals to Existing Support at Home Recommendations

For clients with recommended Support at Home Classifications, the assessor can link their goals defined in the support plan to the existing Support at Home service recommendations.

- From the client's Support plan and services screen, go to the **Goals & Recommendations** tab. Then go to the **Client concerns and goals** section.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: SaH Classification 1

Recommended classification: SaH Classification 4 Agreed

HM Medium

Specified needs - Continence Products

Override reason: Higher level service needs

Override reason description: Require higher level of care

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty in cooking

ADD A GOAL

Goal: Ability to cook

- View the client **GOAL** by selecting the blue expand card icon.
- Then, select the **LINK TO THE EXISTING SAH RECOMMENDATIONS** button.

 **Goal: Ability to cook**

Most relevant domain that goal area relates to:

- Physical function
- Social support
- General health
- Personal health

Client's current strengths and abilities in relation to this goal:
Can move and walk

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Lifting objects and cutting vegetables

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)
- To compensate for a declining function (e.g. can be physical, cognitive or social)
- To receive care for a lost or declining function (e.g. can be physical, cognitive or social)

Motivation to achieve: 6

Status: In Progress

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION	ADD A SERVICE RECOMMENDATION	ADD AN ASSISTIVE TECHNOLOGY
LINK TO AN EXISTING RECOMMENDATION	LINK TO THE EXISTING SAH RECOMMENDATIONS	

3. The Link to the existing SaH recommendations screen displays.

Select a recommendation (classification) from the drop down.

Use the expand icon to expand the service type/s to be linked to this goal.

Then, tick the tickboxes next to the desired service/s.

Finally, select the **SAVE TO PLAN** button

Link to the existing SaH recommendations

All fields marked with an asterisk (*) are required.

Select a recommendation *
SaH Classification 4

Select the services to be linked to this goal:

-  Care management
-  Domestic assistance
-  Home maintenance and repairs
-  Home or community general respite
-  **Meals**
 - ☐ Meal delivery
 - ☒ Meal preparation
 - ☐ Meal delivery
 - ☐ Meal preparation
 - ☒ Meal delivery
 - ☐ Meal preparation
 - ☐ Meal delivery

SAVE TO PLAN CANCEL

4. The linked Support at Home recommendation will be displayed within the relevant client **GOAL** section.


Goal: Ability to cook

Most relevant domain that goal area relates to:

- Physical function
- Social support
- General health
- Personal health

Client's current strengths and abilities in relation to this goal:
Can move and walk

Client's current areas of difficulty or activities where the client needs support in order to achieve this goal:
Lifting objects and cutting vegetables

Focus of the goal for the client:

- To regain a function (e.g. can be physical, cognitive or social)
- To compensate for a declining function (e.g. can be physical, cognitive or social)
- To receive care for a lost or declining function (e.g. can be physical, cognitive or social)

Motivation to achieve: 6

Status: In Progress

Support at Home recommendations:

SaH Classification 4

- Meals:** Meal delivery
- Transport:** Indirect transport
- Personal care:** Assistance with self-care and activities of daily living

Recommendations

Add to this goal:

[ADD A GENERAL RECOMMENDATION](#)
[ADD A SERVICE RECOMMENDATION](#)
[ADD AN ASSISTIVE TECHNOLOGY RECOMMENDATION](#)

[LINK TO THE EXISTING SAH RECOMMENDATIONS](#)

Recording Service Frequency and Intensity

Assessors can record the recommended service frequency and intensity for each service they recommend. This is **not mandatory**.

An assessor can record information that has been discussed with the client or information relating to a client's preference for the intensity of service delivery. This will be provided as a guide to the service provider who will agree the frequency and intensity of services with the client.

Where a client does not wish to access a particular service at that point in time, or only requires infrequent services, you should still create the service recommendation.

The client will be able to access these services at a later date by calling the My Aged Care contact centre to facilitate the sending of electronic referrals from recommendations created in their support plan.

Entering specific information about the services required allows the provider and the contact centre to know whether a service is for a specific purpose only or for an ongoing need.

The information allows the contact centre to decide regarding whether they can make the referral or need to request a Support Plan Review from the assessment organisation.

Add service recommendation

All fields marked with an asterisk (*) are required.

Service Type: *

Priority and dates
Priority: *
Low

Recommended service frequency ? Recommended service intensity ?

Recommend a start date
☐ Yes ☒ No

Recommend a review date
☐ Yes ☒ No

Recommend an end date
☐ Yes ☒ No

Responsibility to action
☐ Assessor ☐ Client ☐ Other

Comments: 0 / 100

Associated goals
☐ To be mobile enough to enjoy gardening and outdoor activities again. ☒ To go to the gym twice per week.

UNLINK THIS RECOMMENDATION FROM ALL GOALS

SAVE TO PLAN CANCEL

Support at Home - Restorative Care Pathway

Overriding to Restorative Care Pathway

Once a client receives an IAT outcome, the assessor can override it to Restorative Care Pathway.

- Go to the client's support plan section and then the Goals & Recommendations tab.
Select **OVERRIDE**.

Support plan and services

GO TO THE ASSESSMENT FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

Identified needs Goals & recommendations Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
IAT Outcome: SaH Classification 4

ACCEPT OVERRIDE

- The Override IAT Outcome pop up appears. Select 'Override IAT Outcome To' as 'SaH Restorative Care Pathway'. Select an override reason and enter a description of the reason. Finally, Select **SAVE TO PLAN**.

You may receive the below warning message prompting you to add recommended services again.

- If the original IAT outcome was a Support at Home classification, you will be asked to review the list of Home Support services. Then, select **SAVE TO PLAN**.

An information banner may display: 'Your request is being processed and may take up to 60 seconds. Once processing finishes you will see the services updated on the screen.'



Your request is being processed and may take up to 60 seconds. Once processing finishes you will see the services updated on the screen.

- The Goals & Recommendations page displays again. Go back to the IAT Outcome and Classification heading to view the overridden outcome.



In case of the Support at Home classification, its classification now displays as 'SaH Restorative Care Pathway'.

Recommend that the client receive
Home support
 (not yet in place)
This recommendation requires a delegate decision

Classification: SaH Restorative Care Pathway
Classification type: Short-term

Home support services:

Domestic assistance: General house cleaning, Laundry services, Shopping assistance
Home maintenance and repairs: Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
Home or community general respite: Community and centre-based respite, Flexible respite
Meals: Meal delivery, Meal preparation
Nursing care: Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
Nutrition: Nutrition supports

Once the classification or recommendation is accepted, a 'Add Home Support services' screen will open to input all the services within each service type available for the classification, their frequency and intensity.

This page will display the 'Home support restorative care management' service chosen as default (greyed out).

Restorative care management

Service	Frequency	Intensity
☒ Home support restorative care management		

Editing IAT Outcome to Restorative Care Pathway

To edit an existing IAT Outcome to the Restorative Care Pathway:

1. Go to the client's support plan via the client record, Current Assessments or Recent Assessments tab.
2. In the client's Goals & Recommendations tab, select 'Edit Classification'.
3. The 'Edit recommended classification' pop up appears.
4. In the 'Override IAT outcome to' drop down, select 'SaH Restorative Care Pathway'. An information banner appears reminding you that adding the RCP will automatically include the AT Medium and the HM Medium classifications as well, and that you can edit or remove these recommendations if required.
5. In the 'Override reason' drop down, select from the following:
 - Has restorative care goals
 - Delay/Prevent ongoing services
 - Needs early intervention care
 - Other.

6. You must enter an explanation for the edit in the 'Override reason description' text box. Finally, select 'Save to Plan'.

Edit recommended classification

Adding SaH Restorative Care Pathway automatically includes AT Medium and HM Medium. You can edit or remove these recommendations if needed.

All fields marked with an asterisk(*) are required.

IAT outcome: SaH Classification 3

Recommended Classification: SaH Classification 4

Classification type: Ongoing

New recommended classification *
SaH Restorative Care Pathway

Classification type: Short-term

To override the result, please specify the reason for the override and describe it for the delegate.

Override reason *

Other
Please select...
Has restorative care goals
Delay/prevent ongoing services
Needs early intervention care
Other

Override reason description *

0/150

SAVE TO PLAN
CANCEL

Recommending Second Unit of Restorative Care Pathway

If the client has an approved and active **Support at Home (SaH) Restorative Care Pathway** on the Support Plan, a second unit of Restorative Care Pathway can be requested for a client within sixteen weeks since the commencement of the Restorative Care Pathway (first unit).

Upon delegate approval of the second unit, a new Restorative Care Pathway approval will be created with an approval start date set to the date on which the delegate approved, and the approval end date is set to the same approval end date of the first unit.

- !** Before recommending or approving a second unit of RCP, confirm that the client has commenced services under their first unit of RCP.
- Do not** approve a second unit of RCP if the client has not commenced their first RCP unit.

Once the second unit is added, the assessor can revert their decision and remove it.

- Go to the Support Plan and Services section, then to the Goals & Recommendations tab. The Existing classification under the IAT Outcome and Classifications heading should be 'SaH Restorative Care Pathway'.

Then, select **ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY**.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment | Existing classification: SaH Restorative Care Pathway

IAT Outcome: SaH Classification 3

ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT | ADD NO CARE TYPE UNDER THE ACT | RECOMMEND A PERIOD OF LINKING SUPPORT | RECOMMEND A P...

Recommend that the client receive **Home Support**

✓ You have successfully started this Support Plan Review. This Review is now assigned to you.

2. Once the **ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY** button is selected, a new window will open with **ADD SECOND UNIT** button to confirm the selection. Selecting the button will then facilitate prompts to generate the RCP – Approval of 2nd unit of funding.

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment | Existing classification: SaH Restorative Care Pathway

IAT Outcome: SaH Classification 3

ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY

Client concerns and goals

ADD AREA OF CONCERN

Concern:

Add second unit of Restorative Care Pathway

The additional funding will be added to the client's existing SaH Restorative Care Pathway episode. The client can utilise this additional funding and any of their remaining funding until the end of their Restorative Care Pathway episode.

IAT outcome: SaH Classification 3

ADD SECOND UNIT | CANCEL

3. The assessor has the option to revert their decision to recommend a second unit of restorative care pathway if the circumstances change by selecting the **REMOVE SECOND UNIT OF RESTORATIVE CARE** button.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment | Existing classification: SaH Restorative Care Pathway

IAT Outcome: SaH Classification 3

REMOVE SECOND UNIT OF RESTORATIVE CARE

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

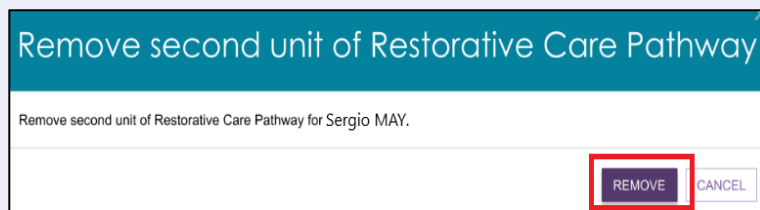
ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT | ADD NO CARE TYPE UNDER THE ACT

Recommend that the client receive **Home Support** | 6 May 2025

SAVE AND SUBMIT FOR DELEGATE DECISION | **RETURN TO CLIENT**

✓ Successfully added second unit of Restorative Care Pathway.

4. Select **Remove** at the confirmation pop up.



Remove second unit of Restorative Care Pathway

Remove second unit of Restorative Care Pathway for Sergio MAY.

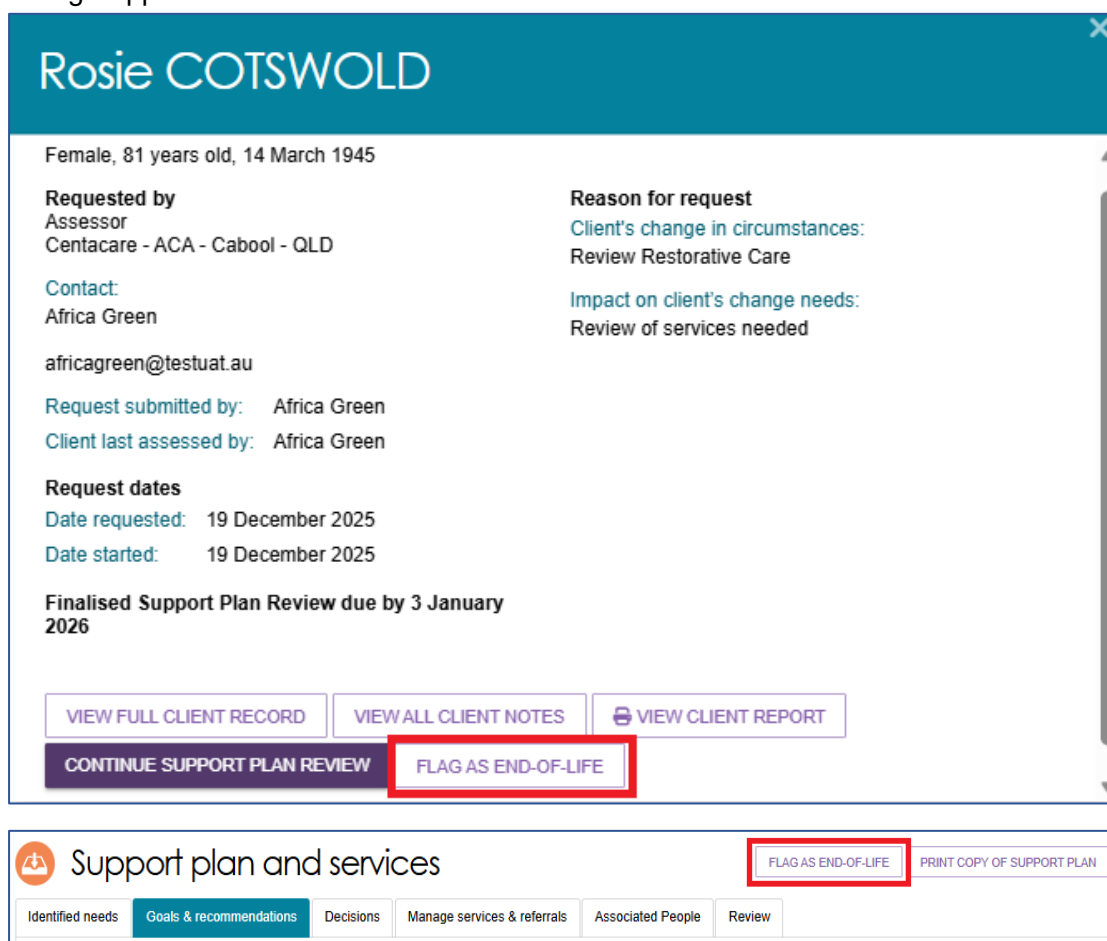
REMOVE CANCEL

End-of-Life Pathway

This section discusses how to edit and override IAT results to include the End-of-Life (EoL) pathway. For clients starting a new [Support Plan Review for services following an EoL episode](#), please refer to the corresponding section of [Support Plan Reviews](#).

- ! Any prospective End of Life pathway clients must be flagged as End-of-life and have their EoL form validated as per current process described in the [Assessment Manual](#).

This can be done during the client's assessment, in the client record, or in the support plan during Support Plan Review.



Rosie COTSWOLD

Female, 81 years old, 14 March 1945

Requested by
Assessor
Centacare - ACA - Cabool - QLD

Contact:
Africa Green
africagreen@testuat.au

Request submitted by: Africa Green
Client last assessed by: Africa Green

Reason for request
Client's change in circumstances:
Review Restorative Care

Impact on client's change needs:
Review of services needed

Request dates
Date requested: 19 December 2025
Date started: 19 December 2025

Finalised Support Plan Review due by 3 January 2026

VIEW FULL CLIENT RECORD **VIEW ALL CLIENT NOTES** **VIEW CLIENT REPORT**

CONTINUE SUPPORT PLAN REVIEW **FLAG AS END-OF-LIFE**

Support plan and services

FLAG AS END-OF-LIFE **PRINT COPY OF SUPPORT PLAN**

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

Validating the End-of-Life Form

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

- Checking the individual's details to ensure they match the record in the portal.
- Verifying the completion of all areas of the Medical Assessment section to confirm:
 1. The individual has a prognosis of a life expectancy of three months or less, and
 2. An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
 3. The medical practitioner or nurse practitioner has completed and signed the form.

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

Overriding to End-of-Life Pathway

To override an existing IAT Outcome to the End-of-life Pathway, the client needs to be flagged as EoL first.

1. Go to the client's support plan. This can be done by searching for the client, or going to the **Plans** tab of their client record and then selecting **SUPPORT PLAN**.
2. Go to the Goals & Recommendations tab of the support plan, and then select the **OVERRIDE TO END-OF-LIFE** button. or the **Edit Classification** button.

The screenshot shows the 'Support plan and services' page with the 'Goals & recommendations' tab selected. Under the 'IAT Outcome and Classifications' section, the 'Current assessment type' is 'Comprehensive Assessment' and the 'IAT Outcome' is 'SaH Classification 2'. The 'Existing classification' includes 'SaH Restorative Care Pathway', 'SaH Restorative Care Pathway (Second Unit)', and 'SaH Classification 2 (Pending allocation)'. A red rectangular box highlights the 'OVERRIDE TO END-OF-LIFE' button located at the bottom left of the classification details.

3. The Override IAT Outcome pop up appears. An information banner appears to let you know that ending the EoL Pathway will automatically add the AT Medium classification into the client's support plan.

You can edit or remove this recommendation if required. However, any Home modifications changes will be removed when overriding to EoL.

×

Override to End-of-Life Pathway

i

Adding SaH End-of-Life Pathway automatically includes AT Medium. You can edit or remove this recommendation if needed.

!

End-of-Life Pathway and Home modifications cannot be recommended together, if any Home modifications changes have been made it will be removed when overriding.

All fields marked with an asterisk (*) are required.

Existing Classification: SaH Classification 2

Classification type: Ongoing

Override existing classification to *

SaH End-of-Life Pathway

Classification type: Short term

To override the result, please specify the reason for the override and describe it for the delegate.

Override reason *

Override reason description: *

0 / 150

OVERWRITE

CANCEL

4. Select the Override reason from the drop down, and enter a description underneath the drop down. Then, select **OVERWRITE**.

Override reason *

Please select...

Please select...

Higher level service needs

Lower level service needs

Other Aged Care Program/s

No Care Approval

0 / 150

Override reason *

Higher level service needs

Override reason description: *

Override reason description here

32 / 150

OVERWRITE

CANCEL

5. If the override is accepted, the client's IAT Outcome and Classifications section will show "SaH End-of-Life Pathway", the override reason and the override reason description.

If applicable, REVERT buttons to the client's previous classification/s may appear.

Support plan and services PRINT COPY OF SUPPORT PLAN

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH Restorative Care Pathway
 IAT Outcome: SaH Classification 2 SaH Restorative Care Pathway (Second Unit)
 Recommended classification: SaH End-of-Life Pathway SaH Classification 2 (Pending allocation)
 AT Medium
 Override reason: Higher level service needs
 Override reason description: Override reason description here
 REVERT TO ONGOING SAH CLASSIFICATION REVERT TO RESTORATIVE CARE

6. If necessary, you will need to [add or edit Home support services](#) to match the EoL Pathway. Select the **Edit** (pencil) icon in the **Home support** section of **Other Recommendations**.

Recommend that the client receive **Home support**

(not yet in place)

This recommendation requires a delegate decision

Classification: SaH End-of-Life Pathway
 Classification type: Short-term
 Home support services:
 Recommended by: My Agedcare Contact Centre

SAVE AND SUBMIT FOR DELEGATE DECISION RETURN TO CLIENT

Flagging End-Of-Life to an existing SaH Restorative Care Pathway

If the review is flagged as End of Life, the assessor can set the classification to **SaH End-of-Life Pathway** when:

- existing classification is **SaH Restorative Care Pathway**
- the End-of Life Pathway form has been verified
- before submitting the Support Plan Review for delegate decision.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage service & referrals Associat

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT outcome: SaH Classification 3
 Recommended classification: SaH Restorative Care Pathway
 OVERRIDE TO END OF LIFE ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY

1. At the client's Goals and Recommendations tab, go to the IAT Outcome and Classifications section, and select the **OVERRIDE TO END OF LIFE** button.

Identified needs | **Goals & recommendations** | Decisions | Manage service & referrals | Associated People

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

OVERRIDE TO END OF LIFE | ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY

2. Check for the information in the recommendations section and select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW** button.

- **Nursing care:** Enrolled nurse clinical care
- **Personal care:** Continence management (non-clinical)

Recommended by: Damien Wayne

COMPLETE AND FINALISE SUPPORT PLAN REVIEW | RETURN TO CLIENT

3. The IAT Outcome and Classifications section will now display the recommendation classification as **SaH End-Of-Life Pathway**.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage service & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH End-Of-Life Pathway

REVERT TO RESTORATIVE CARE

Existing classification: SaH Restorative Care Pathway

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

4. Then, select Save and Submit for Delegate Decision.

- **Transport:** Direct transport
- **Nursing care:** Enrolled nurse clinical care
- **Personal care:** Continence management (non-clinical)

Recommended by: Damien Wayne

SAVE AND SUBMIT FOR DELEGATE DECISION | RETURN TO CLIENT

- ! If there is a change of mind from the client or their supporter guardian that they do not want their assessment to be flagged as **END OF LIFE**, the assessor will have the ability to [Revert to the ongoing classification](#).

5. Enter the outcome of the Support Plan Review from the drop-down menu selection alongside who the plan was conducted with.

Select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW** to finalise the Support Plan Review. The outcome details entered above cannot be edited once the Support Plan Review is complete and will appear on the client's support plan.

Complete & finalise support plan review for Natalie HOLLAND

All fields marked with an asterisk (*) are required.
Reason for this support plan review started on 23 September 2024

Outcome of support plan review *

Details
Please be aware that outcome details entered here cannot be edited once the support plan review is complete and will appear on the client's Support Plan

Support plan conducted with *

COMPLETE & FINALISE SUPPORT PLAN REVIEW CANCEL

- ! If a period of reablement or linking support is added to the client's support plan during a Support Plan Review, the outcome of the review will be automatically set to **Updates to the existing plan**. Once the review is complete, the client's assessment will be open for the assessor to start the support period.

- ! If the outcome of the Support Plan Review is that a new assessment is required, please refer to [Issuing an assessment referral as a result of a Support Plan Review](#).

6. The Support Plan Review will be visible under the **PLANS** tab in the client record.

View support network

Plans

Client summary Client details Support network Approvals **Plans** Attachments Services My Aged Care interactions Notes Tasks and Notifications Residential Funding

Current Episode
Episode ID: 1-1AP86BY2
16 August 2023 - Present
SUPPORT PLAN

Recommendations

- Home Care Package Level 1
- Social support and community engagement
- Meals

Upcoming Review(s)
No upcoming reviews scheduled

Assessment history

- Comprehensive Assessment 16 August 2023
- Home Support Assessment 28 September 2020
- Screening 18 September 2020

Plan history

- Support plan as at 29 September 2020
- Support plan as at 17 July 2023
- Support plan as at 18 August 2023
- Support plan as at 6 May 2025

Review history

- Review 2 May 2025

Reablement and linking support history

Revert End-of-Life Flag

If there is a change of mind from the client or their supporter guardian that they do not want their assessment to be flagged as **END OF LIFE**, the assessor will have the ability to **Revert** to the ongoing classification.

1. Go to the client's profile and go to the **Goals and Recommendations** tab.
2. The IAT Outcome and Classifications page displays. It says that the recommended classification is SaH End-Of-Life Pathway. Select the button underneath to revert to the previous recommendation. The below example shows **Revert to Restorative Care**.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage service & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH

IAT outcome: SaH Classification 3

Recommended classification: SaH End-of-Life Pathway

REVERT TO RESTORATIVE CARE

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

3. Select **Revert** at the confirmation pop up.

Revert to Restorative Care Pathway

Revert SaH End-of-Life Pathway for Sergio MAY back to Restorative Care Pathway.

REVERT CANCEL

4. Once confirmed, the assessor will be taken back to the reverted screen, which is the client's **GOALS AND RECOMMENDATIONS** tab as shown below.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage service & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH Restorative Care Pathway

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

OVERRIDE TO END OF LIFE ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY

Client concerns and goals

Overriding to End-of-Life for Transitioned Home Care Package (HCP) clients

Assessors can override a client's classification from **Transitioned HCP Level 1–4** to **SaH End-of-Life Pathway** during a Support Plan Review, once the End-of-Life Pathway form has been verified. This is necessary because Transitioned clients do not have pre-created services, and tailored Home Support services must be added to meet their end-of-life care needs.

1. Select the Goals & recommendation tab from the client's profile. The Existing classification will display at the IAT Outcome and Classifications section as **Transitioned HCP Level 1–4**. Select the **OVERRIDE TO END OF LIFE** button.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage service & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Home Support Assessment

IAT outcome: HCP

Existing classification: Transitioned HCP Level 2

OVERRIDE TO END OF LIFE

2. A pop-up screen **OVERRIDE TO END-OF-LIFE PATHWAY** will appear prompting to enter relevant information. Upon entering the information select **OVERRIDE**.

Override to End-of-Life Pathway

Warning: End-of-Life Pathway and Home Modifications cannot be recommended together, if any Home Modification changes have been made it will be removed when overriding.

You are changing to a different classification category. Some recommendations may be removed as a result of this change. This will require the services to be added again.

All fields marked with an asterisk(*) are required.

Existing Classification: Transitioned HCP Level 2

Classification type: Ongoing

To override the result, please specify the reason for the override and describe it for the delegate.

Override existing classification to *

SaH End of Life Pathway

Classification type: Short-Term

Override reason *

Higher level service provision needs

Override reason description *

0/100

OVERRIDE **CANCEL**

3. You will be taken to the **ADD HOME SUPPORT SERVICES** page prompting to add the services as required.

Assessors should consider the needs of the client noting the classification approval is for the End-of-Life Pathway.

Tick the desired service/s, add a Frequency and Intensity, and link any goals.

Prefers to speak Chinese [View support network](#)

Add Home Support services

All fields marked with an asterisk(*) are required.

Recommended that the client receive: SaH End-of-Life Pathway
Classification type: Short term

Linked goals

Please select services within each service type *

Domestic Assistance

Services	Frequency	Intensity	Goals
☒ General House Cleaning	Frequency	Intensity	Linked goals
☒ Laundry Services	Frequency	Intensity	Linked goals
☒ Shopping Assistance	Frequency	Intensity	Linked goals
☒ Shopping Assistance	Frequency	Intensity	Linked goals
☒ Shopping Assistance	Frequency	Intensity	Linked goals

Home maintenance and repairs

Services	Frequency	Intensity	Goals
----------	-----------	-----------	-------

4. Select **SAVE TO PLAN**.

☒ Nursing care consumables

Frequency Intensity Linked

Allied health and therapy

Services	Frequency	Intensity	Goals
☐ Allied health assistance	Frequency	Intensity	Linked
☐ Podiatry	Frequency	Intensity	Linked
☐ Social work	Frequency	Intensity	Linked
☐ Speech pathology	Frequency	Intensity	Linked
☐ Diet or nutrition	Frequency	Intensity	Linked
☐ Aboriginal or Torres Strait Islander Health Practitioner assistance	Frequency	Intensity	Linked
☐ Aboriginal or Torres Strait Islander Health Worker assistance	Frequency	Intensity	Linked
☐ Physiotherapy	Frequency	Intensity	Linked
☐ Psychology	Frequency	Intensity	Linked
☐ Exercise physiology	Frequency	Intensity	Linked
☐ Occupational therapy	Frequency	Intensity	Linked
☐ Counselling or psychotherapy	Frequency	Intensity	Linked
☐ Music therapy	Frequency	Intensity	Linked

SAVE TO PLAN CANCEL

5. You will be taken to the **GOALS & RECOMMENDATIONS** page. At this stage you can **REVERT** to the transitioned classification if required.

Select **SAVE AND SUBMIT FOR DELEGATE DECISION**.

! If a client's existing classification is **SaH End-of-Life Pathway**, the Assessor can [override back to Transitioned HCP Level 1-4](#) prior to submitting the Support Plan for delegate decision.

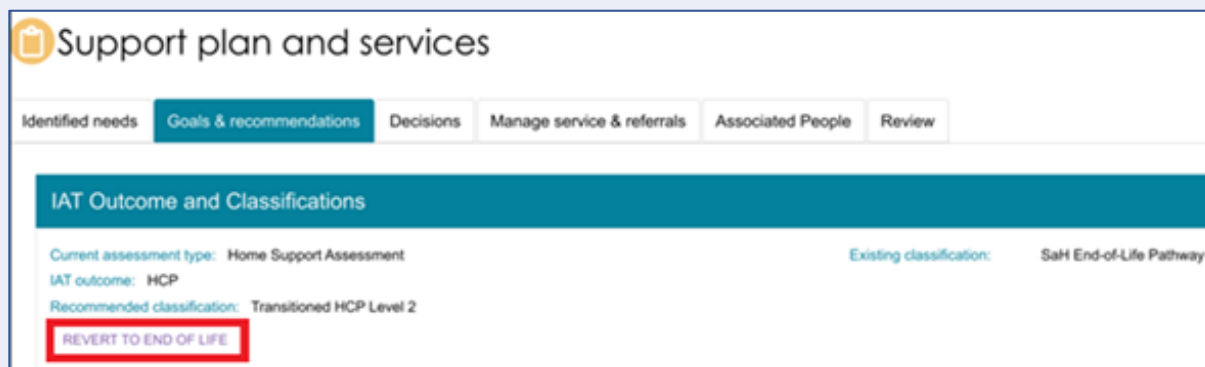
After overriding, the assessor can also [revert to SaH End-of-Life Pathway](#) if required.

Reverting to End-of-Life for Transitioned Home Care Package (HCP) clients

Assessors will have the option to revert the Transitioned HCP classification back to **End of Life**, after overriding the End of Life to the Transitioned classification.

1. Go to the client's **GOALS & RECOMMENDATIONS** screen. The existing classification is SaH End-of-Life Pathway.

Select **REVERT TO END OF LIFE**.



Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage service & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Home Support Assessment
 IAT outcome: HCP
 Recommended classification: Transitioned HCP Level 2

Existing classification: SaH End-of-Life Pathway

REVERT TO END OF LIFE

2. A pop-up screen will appear prompting the user to confirm the action. Select **REVERT**.

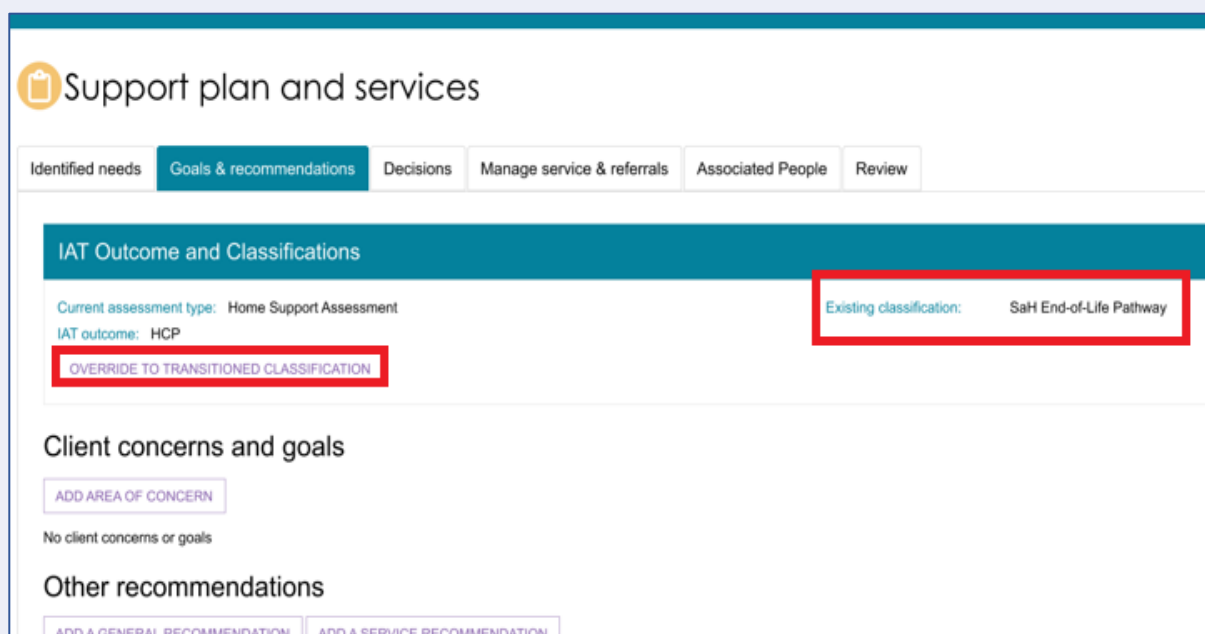


Revert to End-of-Life Pathway

Revert to End-of-Life Pathway for Claire Louise:

REVERT CANCEL

3. You will be directed to the **GOALS & RECOMMENDATIONS** screen.



Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage service & referrals | Associated People | Review

IAT Outcome and Classifications

Current assessment type: Home Support Assessment
 IAT outcome: HCP
 Existing classification: SaH End-of-Life Pathway

OVERRIDE TO TRANSITIONED CLASSIFICATION

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

Completing the Support Plan

Follow these steps to complete the support plan:

1. Confirm that you have [made all service or general recommendations](#), and are satisfied with the [client's goals and concerns](#), as the support plan cannot be edited after it has been completed, except when [the delegate returns the assessment to you](#).
2. Select **COMPLETE SUPPORT PLAN** from any tab in the client's support plan.
3. If the client has a Support at Home classification (ongoing or short-term) but no home address or [MMM \(Modified Monash Model\) classification](#), a pop-up screen will appear while performing this step prompting or reminding the assessor to record the client's home address. The assessor can continue to complete the support plan without recording the address at this stage. Select **CONTINUE TO COMPLETE SUPPORT PLAN**.

- ! The following banner will be displayed if you continue to complete support plan without recording the client's address:

"A home address is required in order to complete the assessment."

4. If the client's address is recorded but their location does not belong to any of Australia's **MMM classifications (MMM1 - MMM7)**, the system will prompt you to update client's MMM classification prior to completing the support plan.

If the MMM Classification is not known, Select **UNKNOWN** from the dropdown menu.

Update client's MMM classification

All fields marked with an asterisk (*) are required.



The client's MMM classification cannot be derived. Please verify that the client's home address is Lot Number 27 SEENEY Street ORLANDO NT 0115. If this address is incorrect please [update the client record](#). If this address is correct, please manually select the client's MMM classification below.

MMClassification: * (?)

Unknown

Select one

MM1 Metropolitan areas

MM2 Regional centres

MM3 Large rural towns

MM4 Medium rural towns

MM5 Small rural towns

MM6 Remote communities

MM7 Very Remote communities

Unknown

5. Select **SAVE TO PLAN** to proceed.

Update client's MMM classification

All fields marked with an asterisk (*) are required.



The client's MMM classification cannot be derived. Please verify that the client's home address is Lot Number 27 SEENEY Street ORLANDO NT 0115. If this address is incorrect please [update the client record](#). If this address is correct, please manually select the client's MMM classification below.

MMClassification: * (?)

Unknown

SAVE TO PLAN

CANCEL

6. You will be taken to the **Decisions** tab to submit for Delegate decision. Go to the bottom of the page and select **SAVE AND SUBMIT FOR DELEGATE DECISION**.

SAVE AND SUBMIT FOR DELEGATE DECISION

RETURN TO CLIENT

7. From the pop-up tick the appropriate box and select **SUBMIT**.

Submit for Delegate decision

You are about to send this assessment and support plan to the Delegate for their decision.

All fields marked with an asterisk (*) are required.

☒ Client applied for care under the Aged Care Act 2024 *

SUBMIT

CANCEL

8. A green banner will then display confirming the assessment and support plan has been sent to the Delegate for their decision.



The assessment and support plan has been sent to the Delegate for their decision

'Returned to Assessor' status

A delegate can return a Support Plan Review (or IAT assessment) to the assessor because amendments to the support plan and/or the IAT are required. It will then have a **Returned to Assessor** status.

Amendments to the IAT

Where the assessment delegate identifies errors in the IAT, they may return the IAT to the you to apply requested changes. The delegate can only do this once per assessment.

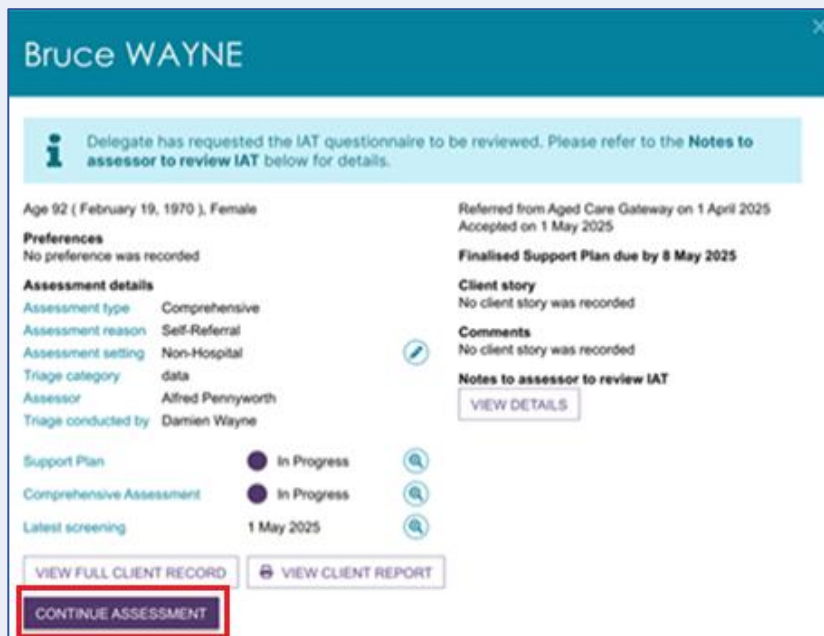
This request can also be viewed from the assessment tab under **Returned to Assessor**.



The image below shows an example of a client's record in Card view when the client's IAT assessment is returned. It contains:

- an information banner: 'Delegate has requested the IAT questions to be reviewed. Please refer to the **Notes to assessor to review IAT** below for details on the instructions provided by the delegate
- '[Notes to assessor to review IAT](#)' section, and a 'View Details' button, at the bottom right of the card

A **Continue Assessment** button at the bottom left of the card will take the assessor into the IAT to action any amendments as per instructions provided by the delegate.



The below image shows the same information banner in the IAT Outcome and Classifications section of the client's Support Plan and Services page, Goals & Recommendations tab. This time, select the **Go to assessment** button at the top right of the screen, to action any amendments as per instructions provided by the delegate.

Support plan and services

GO TO ASSESSMENT FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

Identified needs Goals & recommendations Decisions Manage service & referrals Associated People Review

IAT Outcome and Classifications

i Delegate has requested the IAT questionnaire to be reviewed. Please refer to the [Notes to assessor to review IAT](#) for detail.

Current assessment type: Comprehensive Assessment
 Recommended classification: SaH Classification 3
 Override reason: Higher classification needed
 Override description: Increased in client needs

This image below shows the **Notes to assessor to review IAT** pop up, with example text next to each IAT topic.

Notes to assessor to review IAT

Notes to assessor:

Assessment Details: Lorem ipsum dolor sit amet, consectetur adipiscing elit. Aenean commodo ligula eget dolor. Aenean massa. Cum sociis natoque penatibus et magnis dis parturient montes, nascetur ridiculus mus.

Reason for Assessment: Donec quam felis, ultricies nec, pellentesque eu, pretium quis, sem. Nulla consequat massa quis enim. Donec pede justo, fringilla vel, aliquet nec, vulputate eget, arcu.

Carer profile: In enim justo, rhoncus ut, imperdiet a, venenatis vitae, justo. Nullam dictum felis eu pede mollis pretium. Integer tincidunt. Cras dapibus. Vivamus elementum semper nisi.

Medical and Medications: Aenean vulputate eleifend tellus. Aenean leo ligula, porttitor eu, consequat vitae, eleifend ac, enim. Aliquam lorem ante, dapibus in, viverra quis, feugiat a, tellus.

Function: Phasellus viverra nulla ut metus varius laoreet. Quisque rutrum. Aenean imperdiet. Etiam ultricies nisi vel augue. Curabitur ullamcorper ultricies nisi. Nam eget dui. Etiam rhoncus.

Physical, Personal Health & Frailty: Maecenas tempus, tellus eget condimentum rhoncus, sem quam semper libero, sit amet adipiscing sem neque sed ipsum. Nam quam nunc, blandit vel, luctus pulvinar, hendrerit id, lorem. Maecenas nec odio et ante tincidunt tempus.

Social: Donec vitae sapien ut libero venenatis faucibus. Nullam quis ante. Etiam sit amet orci eget eros faucibus tincidunt. Duis leo. Sed fringilla mauris sit amet nibh.

Cognition: Donec sodales sagittis magna. Sed consequat, leo eget bibendum sodales, augue velit cursus nunc, quis gravida magna mi a libero. Fusce vulputate eleifend sapien.

Behaviour: Vestibulum purus quam, scelerisque ut, mollis sed, nonummy id, metus. Nullam accumsan lorem in dui. Cras ultricies mi eu turpis hendrerit fringilla.

Psychological: Vestibulum ante ipsum primis in faucibus orci luctus et ultrices posuere cubilia Curae; In ac dui quis mi consectetuer lacinia. Nam pretium turpis et arcu.

Home & Personal Safety: Duis arcu tortor, suscipit eget, imperdiet nec, imperdiet iaculis, ipsum.

Financial or Legal: Sed aliquam ultrices mauris. Integer ante arcu, accumsan a, consectetur eget, posuere ut, mauris.

Support Considerations: Praesent adipiscing. Phasellus ullamcorper ipsum rutrum nunc. Nunc nonummy metus. Vestibulum volutpat pretium libero. Cras id dui.

Validated Assessment Tools: Aenean ut eros et nisl sagittis vestibulum.

Other: Nullam nulla eros, ultricies sit amet, nonummy id, imperdiet feugiat, pede. Sed lectus. Donec mollis hendrerit ri

CLOSE

Reviewing and Resubmitting the returned IAT

Follow these steps to review the returned IAT and resubmit the assessment to the delegate.

1. Go to the Assessments tile of the Assessor Portal, then open the client's assessment card or listing listed under the **Current assessments** tab, **Returned to assessor** section.

Current assessments Currently viewing Aussie Healthcare

Current assessments **Recent assessments**

Filter by

Sort by: **Assessment Priority** in order of **High to Low** **GO**

Current sort order is Assessment Priority 1 to 46 out of 46 matching results

Returned to assessor

Jasmine JONES	Alfira BUNG	America KETTLE
WAKERLEY, QLD, 4154 Aged care user ID: AC 76543210 Date accepted: 12 January 2026 Completed Support Plan due by: 22 January 2026	CAMPSIE, NSW, 2194 Aged care user ID: AC22222222 Date accepted: 19 May 2026 Completed Support Plan due by: 8 June 2026	Assessor: Africa Green Delegate: Prospect Free Aged care user ID: AC11111111 Delegate Decision due by: 13 June 2026
Comprehensive 145 days overdue Assessment In Progress High	Comprehensive 8 days overdue Assessment In Progress Medium	Comprehensive 8 days overdue Assessment In Progress Medium

2. Select **View Details** underneath the 'Notes to assessor to review IAT' section, from the client's card or listing.

America KETTLER

Please confirm that , 1 June 1948, 78 Years, AC55555555 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Delegate has requested the IAT questionnaire to be reviewed. Please refer to the **Note to assessor to review IAT** below for details.

Aged 78 (1 June 1948), Male

Referred from Aged Care Gateway on 4 February 2026
Accepted on 5 February 2026

Preferences
No preference was recorded

Finalised Support Plan due by 26 February 2026

Assessment details

Assessment type Home Support

Assessment reason the client is eligible for CHSP

Assessor Africa Green

Triage conducted by Africa Green

Client story
No client story was recorded

Comments

Note to assessor to review IAT
[VIEW DETAILS](#)

Support plan In Progress

Home Support Assessment In Progress

Latest screening 4 February 2026

[VIEW FULL CLIENT RECORD](#) [VIEW CLIENT REPORT](#)

[CONTINUE ASSESSMENT](#)

Alternatively, from the Support plan and services page, go to the Goals & Recommendations tab, then to the IAT Outcome and Classifications section. Select the **Notes to assessor to review IAT** link from the information banner.

Support plan and services

[GO TO THE ASSESSMENT](#) [PRINT COPY OF SUPPORT PLAN](#)

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Delegate has requested the IAT questionnaire to be reviewed. Please refer to the [Note to assessor to review IAT](#) for detail.

Current assessment type: Home Support Assessment

Recommended classification: CHSP

- The 'Notes to assessor to review IAT' pop up appears. It shows a list of the IAT topics, and the Delegate's notes against each topic. Once the assessor receives the instructions from the delegate, they are required to action the requested changes in the relevant sections of the IAT.

These instructions direct the assessor what to amend in the IAT for resubmission.

Select **Close** to go back to the client's assessment card or listing, and select **Continue Assessment**, or select **Go To Assessment** if in the Support Plan and Services page.

- The client's IAT now appears ready for your review to action amendments as per instructions provided by the delegate.

When the IAT is returned to the assessor for amendments, all the Review checkboxes including the Page Review checkboxes on every screen, and the Goals Review button, will be cleared.

The Assessor will need to finalise the IAT again, once all the mandatory questions have been answered, including the Review checkboxes.

Once you have finalised the assessment, assessment delegates are not able to request another review of the IAT.

☒ I have reviewed the information on this page and I confirm that it is correct.*

FINALISE IAT AND GO TO SUPPORT PLAN
 SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN
 CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED

Finalise IAT and go to support plan

Once you select 'Finalise IAT', you cannot make any changes to the responses in this questionnaire, and you will be taken to the Support Plan. Once the IAT is finalised, the system will determine the outcome of the assessment, which can be viewed in the Support Plan.

If you wish to continue with the Support Plan, please select 'Finalise IAT' or if you wish to make any changes to the questionnaire, please select 'Take me back to the assessment'.

[FINALISE IAT](#)
[TAKE ME BACK TO THE ASSESSMENT](#)

- Once the IAT is finalised (for the second time, after review), the client's IAT Outcome may be different. An information banner may appear: 'Please revise the Recommended Classification and Support Plan recommendations based on the new IAT Outcome'.

Support plan and services

[GO TO THE ASSESSMENT](#)
[FLAG AS END-OF-LIFE](#)
[CONVERT TO COMPREHENSIVE ASSESSMENT](#)
[PRINT COPY OF SUPPORT PLAN](#)

[Identified needs](#)
[Goals & recommendations](#)
[Decisions](#)
[Manage services & referrals](#)
[Associated People](#)
[Review](#)

IAT Outcome and Classifications

Please revise the Recommended Classification and Support Plan recommendations based on the new IAT Outcome.

Current assessment type: Home Support Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: CHSP

You will still be required to review all classifications and any prompts triggers (for example Restorative care pathway, Assistive technology, Home modifications). If the intention is to recommend an ongoing Home Support Classification, the assessor must ensure 'Recommended Classification' matches the new 'IAT outcome' via the edit functionality

Otherwise, you may receive a warning message:



Please review and edit classification to align with IAT outcome or existing classification.

If the IAT outcome results in a lower classification than the client's current existing classification, please ensure the Recommended Classification is equivalent to the client's existing Classification level when recommending ongoing home support services through

Support at Home or CHSP.

As per existing functionality, the assessor can override the '*Recommended Classification*' to recommend a short-term pathway or Residential Care if required.

×

Edit recommended classification

All fields marked with an asterisk (*) are required.



In line with legislation, you are not permitted to override the IAT Outcome to recommend a different ongoing home support classification level (e.g., CHSP or SaH class 1-8) nor can you override the IAT Outcome of 'ineligible for CHSP/SaH' to recommend ongoing home support services. If your intent is to recommend ongoing home support services through Support at Home or CHSP, please ensure the recommended classification aligns with the IAT outcome. You can override the IAT outcome to recommend other care types, such as short-term pathways and residential care, in line with guidance provided in the Aged Care Assessment Manual.

Note: If through the IAT review process, the IAT outcome results in a lower classification than the client's current existing classification, please ensure the Recommended Classification is equivalent to the client's existing Classification level when recommending ongoing home support services through Support at Home or CHSP.

IAT outcome:	SaH Classification 1
Recommended Classification:	SaH Classification 1
Classification type:	Ongoing

6. At this stage, you may want (or need) to update the client's support plan as well to reflect the new IAT Outcome and recommendations.

When you have finished reviewing the new IAT classification and/or the support plan, select the **Complete Support Plan** button.

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION **ADD A SERVICE RECOMMENDATION** **ADD AN ASSISTIVE TECHNOLOGY** **ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT**

ADD A CARE TYPE FOR DELEGATE DECISION **RECOMMEND A PERIOD OF LINKING SUPPORT** **RECOMMEND A PERIOD OF REABLEMENT** **ADD NO CARE APPROVAL**

 Recommend that the client receive **Home support** 

 Recommend that the client receive **Home modifications** 

COMPLETE SUPPORT PLAN **REQUEST/CHANGE NOTIFICATION OF SAH CORRESPONDENCE** **RETURN TO CLIENT**

7. The **Note to Delegate** pop up appears. You need to provide notes on what you corrected in the relevant IAT domains that the delegate asked you to review.

The Notes to Delegate text box is mandatory and has the list of IAT Domains pre-filled for your convenience. This text can be updated or removed whilst inputting your notes. Non-clinical assessors must document all clinical supervisor(s) involved throughout the assessment process.

If this text box is not completed, an error message will appear.

Finally, select **CONTINUE TO COMPLETE SUPPORT PLAN**.

Note to delegate

All fields marked with an asterisk (*) are required.

Instructions: Provide information on the corrections against the relevant IAT domains as per the instructions given by the delegate. If a request for a correction was not actioned, provide your reasoning as to why. If applicable, please list all clinical supervisor(s) involved throughout the completion of the IAT and Support plan.

Notes to delegate: *

Assessment Details:

Reason for Assessment:

Carer profile:

Medical and Medications: Amended this section

Function:

Physical, Personal Health & Frailty:

Social:

Cognition: | Added latest test results

Behaviour:

Psychological:

Home & Personal Safety:

Financial or Legal:

Support Considerations:

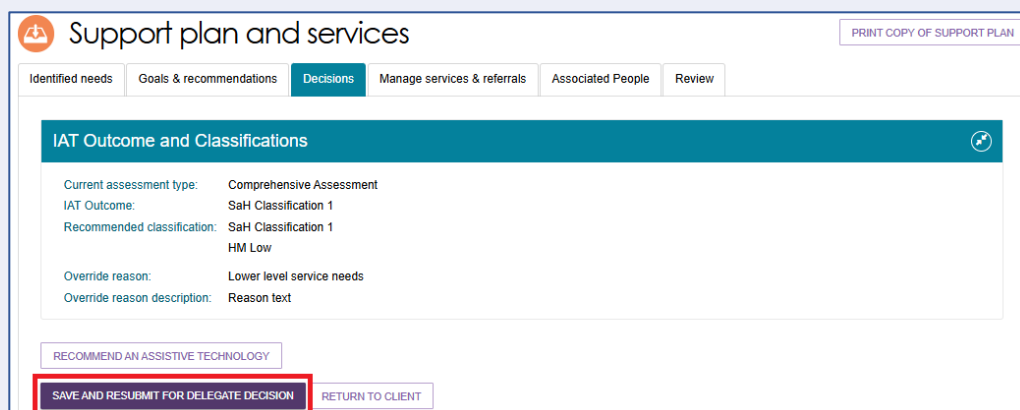
Validated Assessment Tools:

Other: Clinical Supervisor is Jane Doe

374 / 2500

CONTINUE TO COMPLETE SUPPORT PLAN **CANCEL**

8. Once you have completed the changes required or specified by the Assessment Delegate, you will be required to **SAVE AND RESUBMIT FOR DELEGATE DECISION**.



Support plan and services PRINT COPY OF SUPPORT PLAN

Identified needs | Goals & recommendations | **Decisions** | Manage services & referrals | Associated People | Review

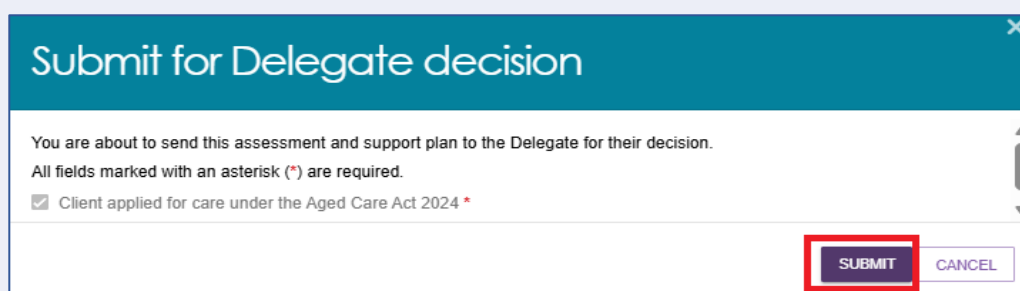
IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 1
 HM Low
 Override reason: Lower level service needs
 Override reason description: Reason text

RECOMMEND AN ASSISTIVE TECHNOLOGY

SAVE AND RESUBMIT FOR DELEGATE DECISION RETURN TO CLIENT

Select **SUBMIT** at the pop up that appears.



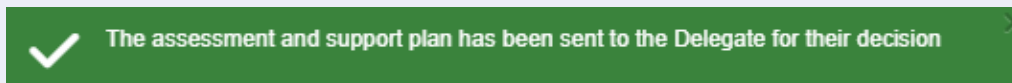
Submit for Delegate decision

You are about to send this assessment and support plan to the Delegate for their decision.
 All fields marked with an asterisk (*) are required.

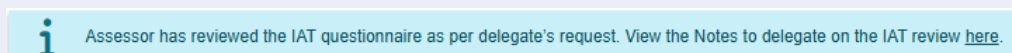
☒ Client applied for care under the Aged Care Act 2024 *

SUBMIT CANCEL

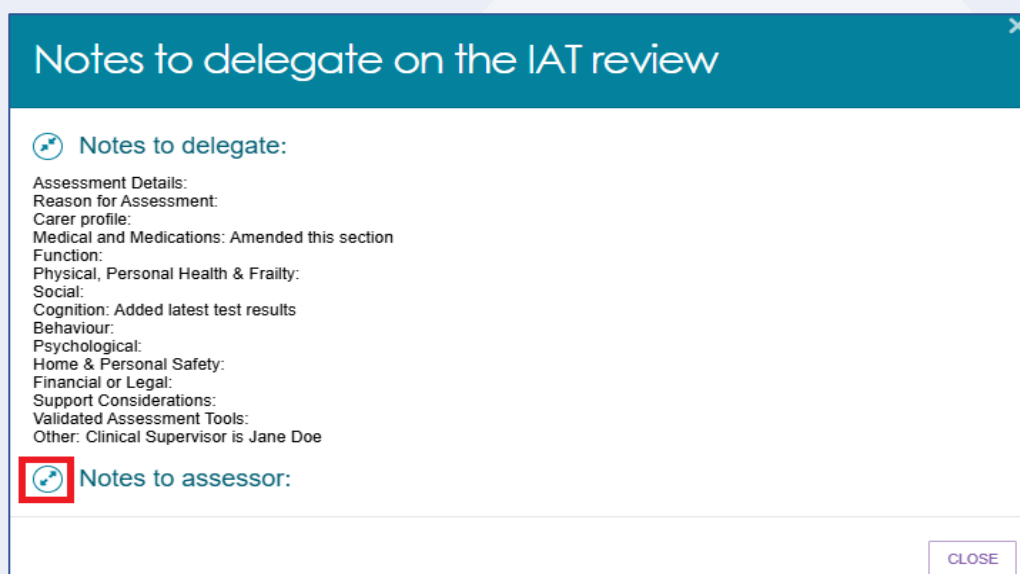
9. If successful, you will receive a message banner stating that the resubmission has been successfully completed and submitted to the Assessment Delegate.



An information banner displays – ‘Assessor has reviewed the IAT questionnaire as per delegate’s request. View the Notes to delegate on the IAT review [here](#)’.



Select the [here](#) hyperlink to view both your Notes to delegate and the delegate’s notes to assessor.



Notes to delegate on the IAT review

Notes to delegate:

Assessment Details:
 Reason for Assessment:
 Carer profile:
 Medical and Medications: Amended this section
 Function:
 Physical, Personal Health & Frailty:
 Social:
 Cognition: Added latest test results
 Behaviour:
 Psychological:
 Home & Personal Safety:
 Financial or Legal:
 Support Considerations:
 Validated Assessment Tools:
 Other: Clinical Supervisor is Jane Doe

Notes to assessor:

CLOSE

Amendments to the support plan

After the assessor has completed the IAT Assessment, completed the support plan, and submitted the recommendation/s for delegate decision, the Delegate may return the Comprehensive assessment or Home Support Assessment for amendments to the support plan.

Returned assessments will display under 'Returned to assessor' in the Assessment Tab.

Triage Not Started

UATAUTOLaurianee
(UATAUTOMicheak)
UATAUTOWALTERY

ZILLMERE, QLD, 4034
Aged care user ID: AC61926523
Date accepted: 13 February 2026
Completed Triage due by: 16 February 2026

Comprehensive 64 days overdue

Triage Not Started High

Returned to assessor

Bart
SIMPSON

Aged care user ID: AC06538466
Date accepted: 11 May 2026
Delegate Decision due by: 11 May 2026

Home Support Due today

Assessors are able to amend the client's concerns and goals, other recommendations, assessment summary and service recommendations according to the instructions provided by the delegate. For further detailed information, please refer to the [Assessment Manual](#).

Finalising the support plan

When you have completed the assessment and the support plan, you will need to arrange referrals for the recommended service(s), before finalising the support plan.

Refer to the [My Aged Care – Assessor Portal User Guide 8 – Referring for services](#) for detailed information on this process.

- ! The client's support plan should be finalised once an effective referral(s) has been made or where the client chose not to proceed with aged care services or to manage their own referrals.

An effective referral is where:

- A referral is accepted by a service provider
- The client has accepted responsibility for managing their own referral
- The outcome of the assessment is that no further action is required by the assessor.

- ! Assessors should not issue CHSP referral codes until after the Assessment Delegate has approved the recommendation.

For more information on how to issue referral codes for CHSP only, please refer to *Chapter 9: Finalising the Assessment and Service Referral* of [My Aged Care Assessment Manual](#), and instructional videos for **comprehensive** and **home support assessments**.

1. From any tab in the client's support plan, you will have the option to **FINALISE SUPPORT PLAN** at the bottom of the page.

Goal: Loris would like funding support for the Occupational Therapy recommendations.

Other recommendations

- Recommend that the client receive **Nursing**
- Recommend that the client receive **Goods, equipment and assistive technology**

FINALISE SUPPORT PLAN **RETURN TO CLIENT**

2. A pop-up box will display, and the referral status for each recommended service type will be pre-populated. Where a referral is **Not Actioned**, you will need to record a reason.
3. If the face-to-face assessment was conducted in a remote location, you should ensure that the **Remote Assessment indicator** is selected before the support plan is finalised.

Finalise support plan

☐ Remote Assessment ?

YES, FINALISE THE SUPPORT PLAN **NO, CANCEL**

Once you have confirmed these outcomes, select **YES, FINALISE THE SUPPORT PLAN**.

Finalise support plan

Are you sure you want to finalise this support plan?
You will not be able to make any changes to the support plan once finalised.

All fields marked with an asterisk (*) are required.

☐ Remote Assessment ?

Service Recommendations

Meals
Outcome
Referral Code Generated [dropdown] ✓

Comments [text area] 0 / 500

Domestic Assistance
Outcome
Referral Code Generated [dropdown] ✓

- General House Cleaning

Comments [text area] 0 / 500

Goods, equipment and assistive technology
Outcome
Referral Code Generated [dropdown] ✓

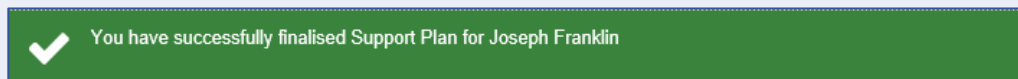
- Support and mobility aids

YES, FINALISE THE SUPPORT PLAN **NO, CANCEL**

! If you are choosing outcomes to support a client located remotely, you can choose **Community-based care**.

Outcome comments are required if you have chosen **Not actioned** or **Community-based care** following a remote assessment. Please provide detailed comments to support your outcome reasons.

4. You will receive a confirmation message that the support plan has been finalised.



Finalising a Support Plan for Support at Home classification

Unlike other recommendations, the screen for finalising the Support Plan for clients' recommended Support At Home classification will not include the individual services to record the outcome. It will be displayed as Support at Home.

Select **YES, FINALISE THE SUPPORT PLAN**.

Ending a period of Reablement or linking support

Assessors can end the period of reablement or linking support, in either one of two ways.

1. End each linking support and/or reablement period individually, by selecting **END LINKING SUPPORT PERIOD** or **END REABLEMENT PERIOD** on the **Goals & recommendations** tab of the clients Support Plan.

Assessors are required to enter the end date for the support period and the outcome.

To finalise the support plan, but keep the support period open, select **FINALISE SUPPORT PLAN & KEEP OPEN FOR SUPPORT PERIOD**.

2. A pop-up box will appear and ask you to finalise the support plan and keep open the support period. To finalise, select **YES, FINALISE THE SUPPORT PLAN**.

3. End all linking support and/or reablement periods at the same time by selecting **SUPPORT**

PERIOD COMPLETE – FINALISE SUPPORT PLAN on the **Goals & Recommendations** tab of the client's support plan.

Support plan and services

GO TO THE ASSESSMENT PRINT COPY OF SUPPORT PLAN

Identified needs **Goals & recommendations** Manage services & referrals Associated People Review

IAT outcome

IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

There are no service recommendations for this client

Recommend that the client receive **Linking Support** END LINKING SUPPORT PERIOD

Recommend that the client receive **Reablement** END REABLEMENT PERIOD

SUPPORT PERIOD COMPLETE - FINALISE SUPPORT PLAN RETURN TO CLIENT

- All periods of linking support and/or reablement that have not ended will be displayed. Assessors are required to enter the end date for each support period and the outcome.

Support period complete - finalise support plan

You are about to end the support period, and finalise the client's support plan.
Where you have not previously provided an end date for each linking support and/or reablement period, it will default to the end date of the support period, as entered below

All fields marked with an asterisk (*) are required.
Are you sure you want to finalise this support plan?
You will not be able to make any changes to the support plan once finalised.

Support Recommendations

The end date for this support period is *
13/09/2024

Linking Support - Access Aged Care services

Outcome of this linking support period *

Comments

Reablement - Mobility

Were the client's goals met? *

Outcome of this reablement period *

Comments

SUPPORT PERIOD COMPLETE - FINALISE SUPPORT PLAN NO, CANCEL



When assessors need to end the period of reablement for client they will be able to access it from the **END REABLEMENT PERIOD** button beside the **Reablement** tile under **Other recommendations**.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

Recommend that the client receive
Meals

Recommend that the client receive
Reablement **END REABLEMENT PERIOD**

5. A pop-up will appear with the title End period of reablement.

Assessors will need to answer two mandatory questions in the **End period of reablement** section in the assessor portal.

The first question asks whether the client's reablement goals were met.

The second question prompts the assessor to detail outcomes by selecting from a drop-down menu.

Mandatory questions will be marked with an asterisk. Assessors should provide further information about the end of period of reablement in the comments box.

End period of reablement

Ending this period of support will not finalise the support plan. To finalise the support plan, select 'Support period complete – finalise support plan' on the 'Goals & recommendations'.

All fields marked with an asterisk (*) are required.

Are you sure you want to end this period of reablement?
You will not be able to make any changes related to this period of reablement when it has ended.

The end date for this reablement period is *

04/12/2018

Were the client's goals met? *

Goals partially met

Outcome of this reablement period *

Incomplete

Comments *

Client entered hospital

23 / 500

END PERIOD OF REABLEMENT CANCEL

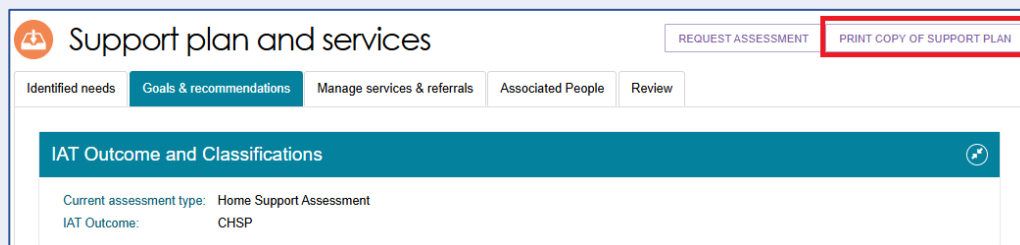
! If a client is undergoing a period of support (linking support and/or reablement), the team leader may contact the assessor asking them to end the period of support in order to assign a Support Plan Review.

Alternatively, the assessor can request that the team leader cancel the review so the assessor can continue the period of support.

Printing a copy of the support plan

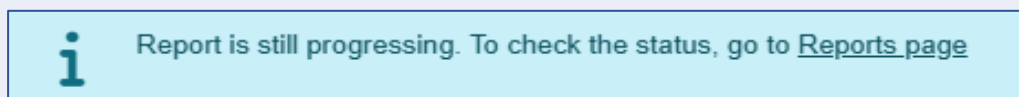
A PDF version of a client's support plan is available to print from the assessor portal. The printed version includes the client's: Last completed Support Plan Review (if applicable), Assessment Summary, Goals & Recommendations (including areas of concern), recommended services, a referral code where applicable, and strategies and any current care approvals.

1. To print a copy of the client's support plan, select the **PRINT COPY OF SUPPORT PLAN** link from the client record or support plan.

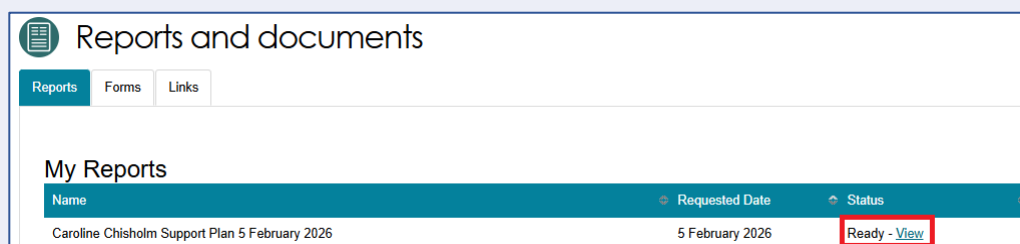


The screenshot shows the 'Support plan and services' page. At the top right, there are two buttons: 'REQUEST ASSESSMENT' and 'PRINT COPY OF SUPPORT PLAN'. The 'PRINT COPY OF SUPPORT PLAN' button is highlighted with a red rectangular box. Below the buttons are tabs for 'Identified needs', 'Goals & recommendations', 'Manage services & referrals', 'Associated People', and 'Review'. The 'Goals & recommendations' tab is selected. Below the tabs, there is a section titled 'IAT Outcome and Classifications' with a sub-section 'Current assessment type: Home Support Assessment' and 'IAT Outcome: CHSP'.

2. A blue banner will appear at the bottom of the screen whilst the report is in progress. Select **Reports page** to navigate to the Reports and documents page.



3. From the Report and documents page select **View**.



The screenshot shows the 'Reports and documents' page. At the top, there are tabs for 'Reports', 'Forms', and 'Links'. The 'Reports' tab is selected. Below the tabs, there is a section titled 'My Reports'. It contains a table with the following data:

Name	Requested Date	Status
Caroline Chisholm Support Plan 5 February 2026	5 February 2026	Ready - View

The 'View' link in the 'Ready' status is highlighted with a red rectangular box.

4. The printer friendly version of the support plan will download. Select your printer options and select **Print**.



SUPPORT PLAN

Support plan

Mrs Caroline CHISHOLM

Aged Care ID: AC33333333

Date of Birth: 30/05/1928

Age: 97 years

About your most recent (support plan review)

Review Date: 04/02/2026
Conducted by: Nasirc Schroederx (UAT SAH Automation Outlet)
Conducted with: Client
Outcome of Review: Updates to the existing plan
Outcome Details:

If a client already has a previous Support Plan Review completed the following section named **Support Plan Review (first completed)** would be displayed before the Goals and Recommendations section.



SUPPORT PLAN

Support plan

Mr Sly Stallone

Aged Care ID: AC76808781

Date of Birth: 09/12/1956

Age: 69 years

Support Plan Review (first completed)

Review Date: 10/02/2026
Conducted by: Elnaq Gibsone (UAT SAH Automation Outlet)
Conducted with: Client
Outcome of Review: Updates to the existing plan
Outcome Details:

Your goals and recommendations

No current concerns, goals or recommendations

General recommendations

No current general recommendations

Your recommended service

Your current care approvals

Home support

SaH End-of-Life Pathway - Short-term - Care management

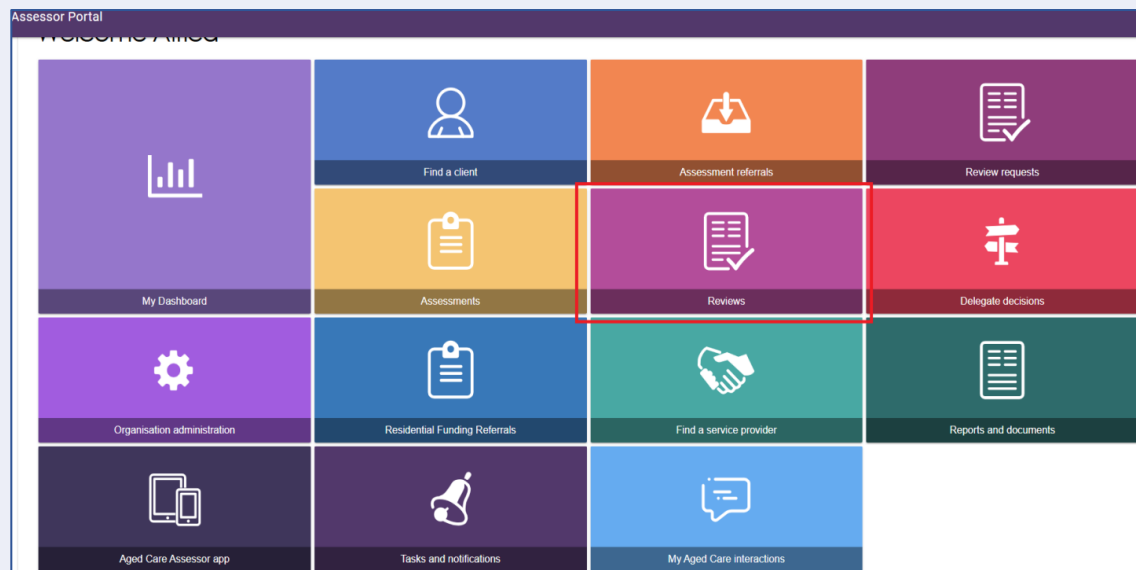
Service:	Approved from:	Approved to:	Emergency approval:	No care reason:
Home support care management	10/02/2026	25/08/2026		



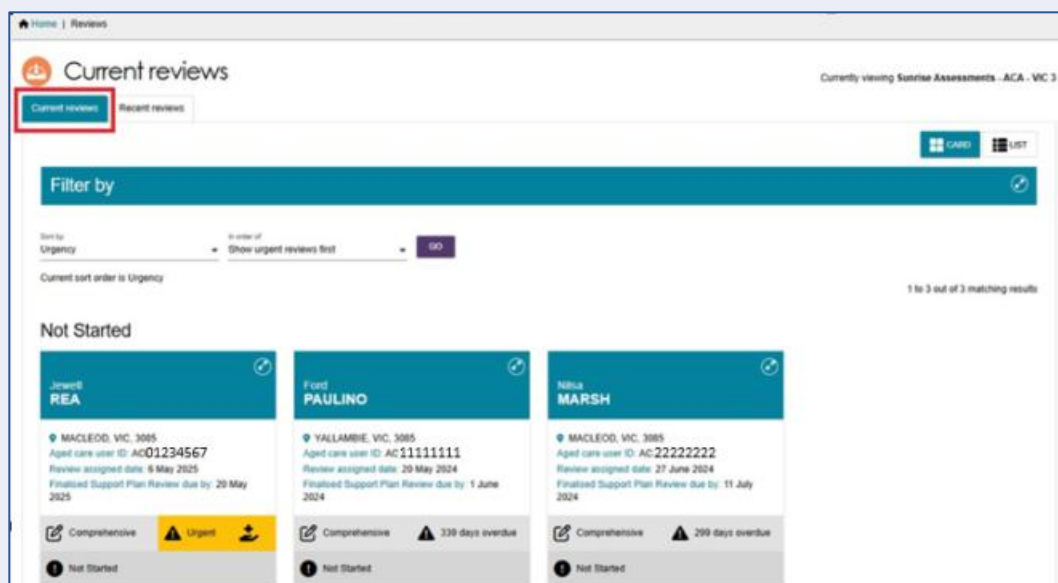
Support Plan Reviews

Viewing a Support Plan Review

1. Select the **Reviews** tile from the homepage to view all Support Plan Reviews assigned to you.



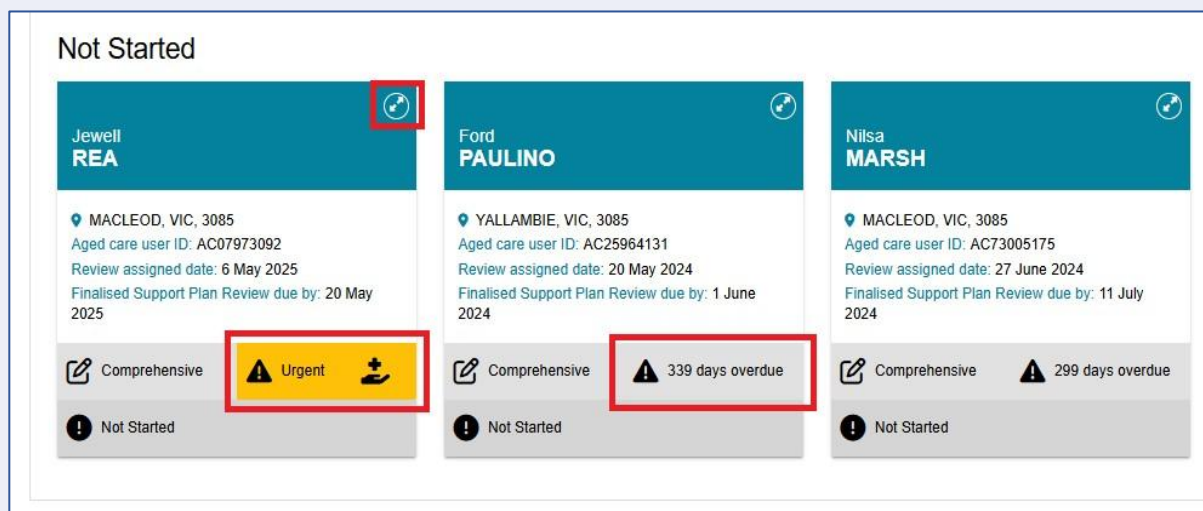
- Go to the **Current reviews** tab to view Support Plan Reviews assigned to you.



- Select the expand button on the top of the review card to see further information.

The card will also display the assessment type, urgency for the Support Plan Review to be completed and if it is currently overdue.

The following example also contains the End-of-Life Pathway symbol.



- If the request is for the End-of-Life Pathway services, select the edit (pencil) button to start verifying or adding the End-of-Life Pathway Form.

Further information on how to verify the End-of-Life Pathway Form can be found in the [My Aged Care Assessment Manual](#).

Jewell REA

Female, 90 years old, 4 August 1935

Requested by
Client

Contact:
Jewell Rea
02 62626262

Request submitted by: Place Jane

Client last assessed by: UAT.Ford UAT.Lovell

Reason for request
Why is this request urgent?
EOL Pathway

Client's change in circumstances:
Needs End-of-Life Pathway

Impact on client's change needs:
EOL pathway required

Request dates
Date requested: 6 May 2025

Finalised Support Plan Review due by 20 May 2025

End-of-Life form verification: Verification not started

[VIEW FULL CLIENT RECORD](#) [VIEW ALL CLIENT NOTES](#) [VIEW CLIENT REPORT](#)

[START SUPPORT PLAN REVIEW](#) [TRANSFER SUPPORT PLAN REVIEW](#)

Not Started Not Started

Starting a Support Plan Review

Follow these steps to start a Support Plan Review that has been assigned to you:

1. Expand the client card in either card or list view. The Client Summary page displays. Select **START SUPPORT PLAN REVIEW**.

1800 836 799 Mon-Fri 8am - 8pm Sat 10am - 2pm Welcome Rose

Assessor Portal Logout

Home | Find a client | Michele JAMISON (Eloy)

Mr Michele N JAMISON (Eloy)
Male, 93 years old, 10 January 1930, AC75850339
1007 IMBURG WAY GREENWAY, ACT, 2900

Primary contact: Michele Jamison (self) - 61 62626262
No support relationships recorded

Client summary REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT REPORT **START SUPPORT PLAN REVIEW**

Client summary Client details Support network Approvals Plans Attachments Services My Aged Care interactions Notes

Tasks and Notifications

Client tracker

Client summary

Assessments

Assessment	Status
Home Support Assessment	Screening
Finalised on 9 February 2023 Community Aged Care 02 0404 040 404	Complete on 12 June 2020

Alternatively, from the Current reviews page you can also expand the client card and select **START SUPPORT PLAN REVIEW**.

Current reviews

Current reviews Recent reviews

Filter by

Urgency

Current sort order is Urgency

In Progress

Ran NEWKIRK

MACLEOD, VIC, 3095
Aged care user ID: AC66879008
Review assigned date: 27 June 2024
Finalised Support Plan Review due by: 12 July 2024

Stacie HOLLINGSWORTH

Female, 77 years old, 5 November 1948

Requested by
Assessor
Sunrise Assessments - ACA - VIC 3

Contact:
UAT Ford UAT Lovell
02 0404 040 040
marquise.asncrat@tesua
lau

Reason for request:
Client's change in circumstances:
Review AI tier
Impact on client's change needs
test

Request submitted by: UAT Ford UAT Lovell
Client last assessed by: UAT Ford UAT Lovell

Request dates
Date requested: 1 May 2025
Date started: 1 May 2025

Finalised Support Plan Review due by 16 May 2025

VIEW FULL CLIENT RECORD VIEW ALL CLIENT NOTES VIEW CLIENT REPORT

CONTINUE SUPPORT PLAN REVIEW FLAG AS END OF LIFE

1 to 6 out of 6 matching results

Urgent - 304 days overdue

313 days overdue

Due in 4 days

Some assessments have overdue SLAs and need to be scheduled

- From the Before you start the Support Plan Review pop-up select either **CONTINUE TO SUPPORT PLAN REVIEW** or **RECOMMEND A NEW ASSESSMENT**.

Select **CONTINUE TO SUPPORT PLAN REVIEW** to start the Support Plan Review for the client.

If the client's circumstances have changed significantly and there is clear evidence (i.e. a letter from a GP or allied health professional) to demonstrate that they need higher level care, you can issue a referral directly for a new assessment rather than completing a Support Plan Review by selecting the button **RECOMMEND A NEW ASSESSMENT**.



! There is no SPR required to extend an EoL episode from 12 weeks to 16 weeks. This process occurs automatically. Completing an SPR during a current EoL episode will end date the EoL funding immediately.

Before you start the Support Plan Review

All fields marked with an asterisk (*) are required.

If the client's circumstances have changed to any of these scenarios from their initial Support Plan:

- Needs Transition care; or
- Needs Residential care; or
- Needs Residential respite; or
- Client has relocated; or
- Needs End-of-Life Pathway (if not ongoing SaH client); or
- Needs services after End-of-Life Pathway (if not ongoing SaH client); or
- Needs Assistive Technology or Home Modification services (if not AT or HM in place); or
- Needs a new or different SaH classification; or
- Needs CHSP classification; or
- Needs Restorative care Pathway; or
- Needs services after Restorative Care Pathway

you have the option to "Recommend a New Assessment" instead of Support Plan Review.

Otherwise, a Support Plan Review must be undertaken to assess and accommodate changes in the client's current circumstances.

CONTINUE TO SUPPORT PLAN REVIEW

RECOMMEND A NEW ASSESSMENT

CANCEL

3. A pop-up will display asking if the client consents to share their information with My Health Record. Select **No** or **Yes** based on the client's response and select who this decision was made by from the drop-down menu.

If consent is provided by a supporter guardian, then their first name must be entered before proceeding.

Consent to share information with My Health Record

All fields marked with an asterisk (*) are required.

Information

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

Does the client consent to share their Support Plan with My Health Record (MHR)? *

☐ No ☐ Yes

Consent decision by *

Decision made by

Decision made by

Client

Supporter Guardian

0 / 255

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

4. If the client does not consent to share their support plan with My Health Record you will also be required to enter a consent denial reason before selecting **CONTINUE TO SUPPORT PLAN REVIEW**. If the consent is not provided by the client's supporter guardian, their first name must be entered along with the denial reason before proceeding.

Consent to share information with My Health Record

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

Does the client consent to share their Support Plan with My Health Record (MHR)? *

☒ No ☐ Yes

Consent decision by *

Client

Consent denial reason *

Please select a reason for not providing the consent

Please select a reason for not providing the consent

Do not wish to disclose

Other

Privacy concerns

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

5. Select **CONTINUE TO SUPPORT PLAN REVIEW**.

Consent to share information with My Health Record

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

Does the client consent to share their Support Plan with My Health Record (MHR)? *

☐ No
 ☒ Yes

Consent decision by *

Supporter Guardian

Supporter Details

First name: *

Roger

Last name:

Yeast

Comments:

0 / 255

[CONTINUE TO SUPPORT PLAN REVIEW](#)
[CANCEL](#)

6. Once a Support Plan Review has been started, an assessor will be able to make changes to information in the following sections of the client's support plan:

- Assessment summary
- Client motivations
- Goals & recommendations (including recommendations for linking support & reablement)
- Manage services & referrals
- Associated People
- Review.

When finished, select **COMPLETE & FINALISE SUPPORT PLAN REVIEW**.

Support plan and services

[FLAG AS END-OF-LIFE](#)
[PRINT COPY OF SUPPORT PLAN](#)

[Identified needs](#)
[Goals & recommendations](#)
[Decisions](#)
[Manage services & referrals](#)
[Associated People](#)
[Review](#)

IAT Outcome and Classifications

Client concerns and goals

[ADD AREA OF CONCERN](#)

Concern:
 Concern text

[ADD A GOAL](#)

Other recommendations

[ADD A GENERAL RECOMMENDATION](#)
[ADD A SERVICE RECOMMENDATION](#)
[RECOMMEND A PERIOD OF LINKING SUPPORT](#)
[RECOMMEND A PERIOD OF REABLEMENT](#)

Recommend that the client receive Domestic assistance 30 November 2024

Recommend that the client receive Transport 30 November 2024

[COMPLETE & FINALISE SUPPORT PLAN REVIEW](#)
[RETURN TO CLIENT](#)

! Previously recommended CHSP, MPS or NATSIFAC services

For clients who had CHSP, MPS and/or NATSIFAC services recommended before 23 February 2026, assessors cannot delete these services in the client's IAT assessment during the support plan review or when the support plan is 'Undergoing Support'. The below image shows the Goals & Recommendations section of a client's support plan. Historical CHSP, MPS or NATSIFAC services do not have the Delete button available.

The screenshot shows the 'Assessor Portal' interface. The top navigation bar includes links like 'My Dashboard', 'Find a client', 'Assessments', 'Reviews', 'Organisation administration', 'Residential Funding Referrals', 'AN-ACC app', 'Find a service provider', 'Reports and documents', 'MyAssessor app', 'Tasks and notifications', and 'My Aged Care interactions'. The main content area is titled 'Mr Rosec WILLIAMS (Preferred)' and includes client details: 'Male, 81 years old, 10 October 1943, AC 12345678, 20 EASTY STREET PHILLIP ACT, 2007, Requires National Relay Service and Urdu translator'. The 'Primary contact' is 'Rosec Williams (self)' and 'No support relationships recorded'. The 'Client concerns and goals' section has an 'ADD AREA OF CONCERN' button and states 'No client concerns or goals'. The 'Other recommendations' section has buttons for 'ADD A GENERAL RECOMMENDATION' and 'ADD A SERVICE RECOMMENDATION'. It lists three recommendations: 'Domestic assistance' (dated 16 May 2019), 'Meals' (dated 20 August 2025), and 'Reablement'. The 'Domestic assistance' and 'Linking Support' recommendations are highlighted with a red box, indicating they are historical services. The 'Recommend for Comprehensive Assessment' section has a 'RECOMMEND FOR COMPREHENSIVE ASSESSMENT' button. At the bottom, there are buttons for 'SUPPORT PERIOD COMPLETE - FINALISE SUPPORT PLAN' and 'RETURN TO CLIENT'.

- The **Complete & finalise support plan review** page appears. Fill in all mandatory fields including Outcome of support plan review, and who the Support plan was conducted with. Optionally for each service recommendation you can fill in the outcome and comments. Then, select **COMPLETE & FINALISE SUPPORT PLAN REVIEW**.

Complete & finalise support plan review for Alistair Koenig

All fields marked with an asterisk (*) are required.

Reason for this support plan review started on 11 June 2026

Change in care needs

Outcome of support plan review *

Please provide an outcome of support plan review.

Details

Please be aware that outcome details entered here cannot be edited once the support plan review is complete and will appear on the client's Support Plan ?

0 / 1000

Support plan conducted with *

Please select conducted with.

Service Recommendations

Domestic assistance

Outcome

Referral Code Generated

Comments

0 / 500

COMPLETE & FINALISE SUPPORT PLAN REVIEW

CANCEL

Accessibility Privacy Disclaimer Terms of use
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Please provide an outcome of support plan review.
Please select conducted with.



- If the [SPR outcome is a reassessment](#), you will be prompted to enter the outcome of the review, the reason for the new assessment referral, then select an organisation of which to issue the referral. This can only be done in circumstances where a client requires one or more of the following:
 - Transition care
 - Residential care
 - Residential respite
 - Client has relocated
 - End-of-Life Pathway (if not ongoing SaH client)
 - Services after End-of-Life Pathway (if not ongoing SaH client)
 - Assistive Technology or Home Modification services (if not AT or HM in place)
 - A new or different SaH classification; or
 - CHSP classification
 - Restorative care Pathway
 - Services after Restorative Care Pathway



A new assessment after the End-of-Life Pathway is only required where the person did not receive an inactive SaH classification at their initial assessment. Otherwise, continue to Support Plan Review, unless a reassessment is required to reflect changes in the person's needs or circumstances.

Recommending a new assessment

Follow these steps if the client's circumstances have changed and it is more appropriate to issue a referral directly for a new assessment rather than completing a Support Plan Review:



1. Expand the client card in either card or list view. The Client Summary page displays. Select **START SUPPORT PLAN REVIEW**.

Assessor Portal Logout

Home | Find a client | Michele JAMISON (Eloy)

Mr Michele N JAMISON (Eloy)
 Male, 93 years old, 10 January 1930, AC 87654321
 1000 MBURG WAY GREENWAY, ACT, 2900

Primary contact: Michele Jamison (self) - 61 0404 040 0404
 No support relationships recorded

Client summary REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT REPORT **START SUPPORT PLAN REVIEW**

Client summary | Client details | Support network | Approvals | Plans | Attachments | Services | My Aged Care interactions | Notes

Tasks and Notifications

Client tracker

Client summary

Assessments

Home Support Assessment	Screening
Finalised on 9 February 2023 Community Aged Care 02 6262 6262	Complete on 12 June 2020

Alternatively, from the Current reviews page you can also expand the client card and select **START SUPPORT PLAN REVIEW**.

Current reviews Recent reviews

Filter by

Sort by: Urgency Show urgent review

Current sort order is Urgency

In Progress

Ilan NEWKIRK

MACLEDD, VIC, 3085
 Aged care user ID: AC66879008
 Review assigned date: 27 June 2024
 Finalised Support Plan Review due by: 12 July 2024

Comprehensive Urgent - 304 days overdue

In Progress

Stacie HOLLINGSWORTH

Female, 77 years old, 5 November 1948

Requested by
 Assessor: Sunrise Assessments - ACA - VIC 3

Contact
 UAT Ford UAT Lovell
 02 6161 6161
 marquise.ashcraft@tesua.tau

Request submitted by: UAT Ford UAT Lovell
Client last assessed by: UAT Ford UAT Lovell

Reason for request
 Client's change in circumstances:
 Review AT tier
 Impact on client's change needs:
 test

Request dates
 Date requested: 1 May 2025
 Date started: 1 May 2025

Finalised Support Plan Review due by 16 May 2025

VIEW FULL CLIENT RECORD VIEW ALL CLIENT NOTES VIEW CLIENT REPORT

CONTINUE SUPPORT PLAN REVIEW FLAG AS END OF LIFE

1 to 6 out of 6 matching results

Currently viewing Sunrise Assessments - ACA - VIC 3

Some assessments have overdue SLAs and need to be scheduled.

2. From the Before you start the Support Plan Review pop-up select **RECOMMEND A NEW ASSESSMENT**.

Before you start the Support Plan Review

All fields marked with an asterisk (*) are required.

If the client's circumstances have changed to any of these scenarios from their initial Support Plan:

- Needs Transition care; or
- Needs Residential care; or
- Needs Residential respite; or
- Client has relocated; or
- Needs End-of-Life Pathway (if not ongoing SaH client); or
- Needs services after End-of-Life Pathway (if not ongoing SaH client); or
- Needs Assistive Technology or Home Modification services (if not AT or HM in place); or
- Needs a new or different SaH classification; or
- Needs CHSP classification; or
- Needs Restorative care Pathway; or
- Needs services after Restorative Care Pathway

you have the option to "Recommend a New Assessment" instead of Support Plan Review.

Otherwise, a Support Plan Review must be undertaken to assess and accommodate changes in the client's current circumstances.

CONTINUE TO SUPPORT PLAN REVIEW

RECOMMEND A NEW ASSESSMENT

CANCEL

3. A pop up appears to complete or finalise the support plan review and to refer your client for assessment.

a) Select the reason for the new assessment. The values available are:

- Needs Transition care
- Needs Residential care
- Needs Residential respite
- Client has relocated
- Needs End of Life pathway (not Support at Home client)
- Needs services post-End of Life pathway (only for non Support at Home clients e.g., CHSP clients)
- Needs Assistive technology or Home modification (none in place)
- Needs new or different Support at Home classification
- Needs Commonwealth Home Support Program classification
- Needs Restorative Care pathway
- Needs services post-Restorative Care pathway.

Complete/finalise Support Plan Review & Refer Stacey SMITH for assessment

! Before you send this referral for a new assessment, contact the Assessment Organisation you want to refer the client to. Please provide as much information as possible in the comments box below to assist the receiving organisation. Please ensure that you have client consent before sending this referral.

All fields marked with an asterisk (*) are required.

What is the reason for the new assessment? *

Select one

- Needs Transition Care
- Needs Residential Care
- Needs Residential Respite
- Client has relocated
- Needs EoL - not SaH client
- Needs services post EoL-not SaH
- Needs AT or HM - none in place
- Needs new/different SaH class
- Needs CHSP Class
- Needs RC Pathway
- Needs services post RC Pathway

- b) Assign this referral to either yourself or your organisation, or another organisation.
- c) Choose the assessment type- Home support or Comprehensive. For Comprehensive, select the outlet.
- d) Select the assessment priority
- e) Add any comments if necessary.
- f) Select **COMPLETE/FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT**.

Assign this referral to:*

☒ Myself / My organisation

☐ Another Organisation

Please select the assessment type: *

Comprehensive Assessment

Please select outlet for this referral *

ABC Outlet

Assessment setting: * ?

☐ Hospital

☒ Non-Hospital

Priority * ?

Medium

Comments:

Comment text here

COMPLETE/FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT CANCEL

Issuing an assessment referral as a result of a Support Plan Review

When completing a Support Plan Review, an assessor can refer the client for a new assessment. This is completed during the **Complete & finalise Support Plan Review** page.

1. In the Complete and Finalise Support Plan Review section of the client's support plan, select **A new assessment required**.

Home | Reviews | Tomasa GUINN support plan and services | Finalise details

Complete & finalise support plan review for Tomasa Guinn

All fields marked with an asterisk (*) are required.

☐ Remote Assessment ?

Reason for this support plan review started on 27 May 2026
Change in care needs

Outcome of support plan review *

A new assessment required

Not selected

No changes to support plan

Updates to the existing plan

A new assessment required

SPR cancelled

Other

2. Complete all mandatory sections of the **Complete & finalise support plan review** page.

3. At the bottom of the page, you will be required to issue a new assessment referral before completing the review. You can send the assessment referral to yourself or your organisation, or to another organisation. Select the appropriate option.

Assign this referral to:*

- ☐ Myself / My organisation
☐ Another Organisation

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT

NO, CANCEL

If you choose **Myself / My Organisation**, you will be prompted to select the assessment type, outlet for referral, assessment setting (if you've selected a Comprehensive Assessment) and indicate the priority of the referral. Optionally you can add comments.

Then, select **COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT**.

Assign this referral to:*

- ☒ Myself / My organisation
☐ Another Organisation

Please select the assessment type: *

Comprehensive Assessment

Please select outlet for this referral *

Example Outlet

Assessment setting: * ?

- ☐ Hospital
☒ Non-Hospital

Priority * ?

Medium

Comments:

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT

NO, CANCEL

If you choose **Another Organisation**, you will be required to indicate the type of assessment required and the assessment setting (if Comprehensive Assessment has been selected).

Then, search for the assessment organisation's address by either using the client's address, or enter an alternative assessment address.

If you selected **Use the client's address**, any alternative assessment addresses that the client has will be removed from the client's profile when the referral is issued.

Assign this referral to:*

☐ Myself / My organisation

☒ **Another Organisation**

Please select the assessment type: *

Comprehensive Assessment

 By selecting client's address, the alternative assessment address will be removed from client's profile when the referral has been issued.

Assessment setting: ?

☐ Hospital

☒ Non-Hospital

Search for Assessment Organisation: *

☒ **Use the client's address**

Client address

 Unit 32 Lot Number 192 5 OXLEY Avenue MARGATE QLD 4019

☐ Enter an alternative assessment address

 Unit 32 Lot Number 192 5 OXLEY Avenue MARGATE QLD 4019  

SEARCH

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT **NO, CANCEL**

If you **enter an alternative assessment address**, you can use either the one displayed, or select the Pencil (**Edit**) button to enter a different address.

Search for Assessment Organisation: *

☐ Use the client's address

Client address

 Unit 32 Lot Number 192 5 OXLEY Avenue MARGATE QLD 4019

☒ **Enter an alternative assessment address**

 Lot Number 193 OXLEY AVENUE, MARGATE, QLD, 4019  

Select **SEARCH**, then select the desired assessment organisation.

Once you have selected an assessment organisation you will be asked to enter the priority of the assessment. Optionally you can add comments.

4. Finally, select **COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT**.

SEARCH

Select Assessment Organisation*

☐ Assessment 123 - ACA - Canberra ACT, PH 02 6161 6161

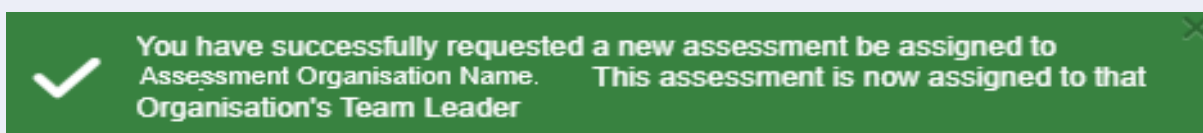
☒ Aged Care Assessor 321 - ACA - Canberra ACT Ph 02 6262 6262

Priority * ?
Medium

Comments:
Comments description

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT NO, CANCEL

5. Upon completing the Support Plan Review, a green banner will display to confirm the referral has been issued.



The new assessment will appear under the Current assessments tab if you have assigned it to yourself or appear in the Incoming referrals queue for a team leader if assigned to My Organisation or Another Organisation.

! All assessments, including those generated from Support Plan Reviews are required to undergo triage.

For more information refer to [My Aged Care – Assessor Portal User Guide 3 – Managing referrals for assessment and support plan reviews](#).

Ad hoc Support Plan Reviews

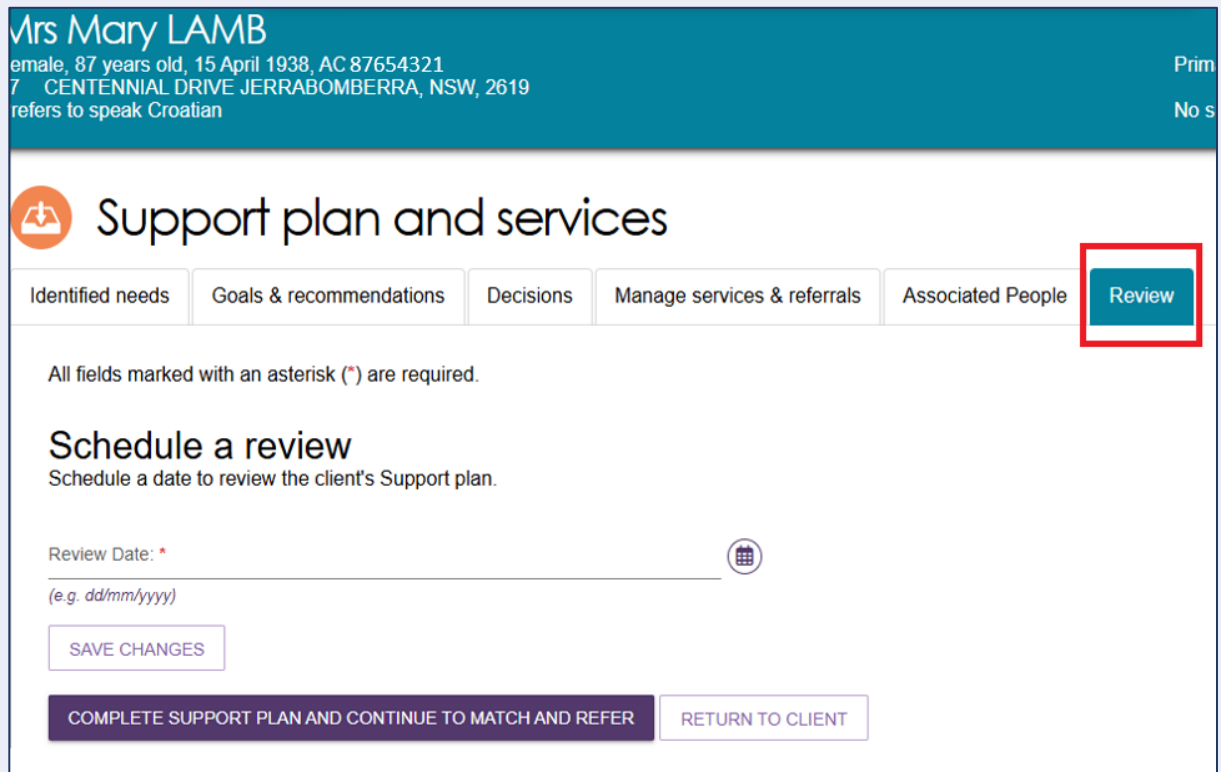
You will be able to start an ad hoc Support Plan Review for any client who has been assessed by your assessment outlet, without requiring a Support Plan Review to be assigned to you. This can be done from any tab within the client record by selecting **START SUPPORT PLAN REVIEW** or via selecting the client card from the **CURRENT REVIEWS** page.

An ad hoc review will override a scheduled review. In this instance the team leader should cancel the scheduled review in their upcoming review tab if it is no longer required.

Scheduling an Ad hoc Support Plan Review

An **ad hoc** Support Plan Review can be scheduled by the assessor outside the usual review schedule, typically when there is a significant change in the client's needs, health, or circumstances that affect the level or type of care they require.

1. To schedule an ad hoc Support Plan Review, navigate to the **REVIEW** tab under **SUPPORT PLAN AND SERVICES** screen.



Mrs Mary LAMB
Female, 87 years old, 15 April 1938, AC 87654321
7 CENTENNIAL DRIVE JERRABOMBERRA, NSW, 2619
refers to speak Croatian

Prim
No s

Support plan and services

Identified needs | Goals & recommendations | Decisions | Manage services & referrals | Associated People | **Review**

All fields marked with an asterisk (*) are required.

Schedule a review

Schedule a date to review the client's Support plan.

Review Date: * 

(e.g. dd/mm/yyyy)

[SAVE CHANGES](#)

[COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER](#) [RETURN TO CLIENT](#)

2. Select the **CALENDAR** icon under **SCHEDULE A REVIEW**, pick a future date for review and select the **SAVE CHANGES** button.

Mrs Mary LAMB

Female, 87 years old, 15 April 1938, AC87654321
CENTENNIAL DRIVE JERRABOMBERRA, NSW, 2619
Refers to speak Croatian

Primary

No s



Support plan and services

Identified needs

Goals & recommendations

Decisions

Manage services & referrals

Associated People

Review

All fields marked with an asterisk (*) are required.

Schedule a review

Schedule a date to review the client's Support plan.

Review Date: *



(e.g. dd/mm/yyyy)

SAVE CHANGES**COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER**

RETURN TO CLIENT



3. Select **COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER**.

Support plan and services

Identified needs | Goals & recommendations | Decisions | Manage services & referrals | Associated People | **Review**

All fields marked with an asterisk (*) are required.

Schedule a review
Schedule a date to review the client's Support plan.

Review Date: * 
(e.g. dd/mm/yyyy)

SAVE CHANGES

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER | RETURN TO CLIENT

4. You will notice the **START SUPPORT PLAN REVIEW** button on the top right hand side of the client's **PLANS** tab. Select **START SUPPORT PLAN REVIEW**.

REFER THIS CLIENT FOR ASSESSMENT | VIEW CLIENT REPORT | **START SUPPORT PLAN REVIEW**

Approvals | **Plans** | Attachments | Services | My Aged Care interactions | Notes | Tasks and Notifications

Assessment history 

 Comprehensive Assessment 9 May 2025

5. Select **CONTINUE TO SUPPORT PLAN REVIEW** button on the next screen

Before you start the Support Plan Review 

All fields marked with an asterisk (*) are required.

If the client's circumstances have changed to any of these scenarios from their initial Support Plan:

- Needs Transition care; or
- Needs Residential care; or
- Needs Residential respite; or
- Client has relocated; or
- Needs End-of-Life Pathway (if not ongoing SaH client); or
- Needs services after End-of-Life Pathway (if not ongoing SaH client); or
- Needs Assistive Technology or Home Modification services (if not AT or HM in place); or
- Needs a new or different SaH classification; or
- Needs CHSP classification; or
- Needs Restorative care Pathway; or
- Needs services after Restorative Care Pathway

you have the option to "Recommend a New Assessment" instead of Support Plan Review.

Otherwise, a Support Plan Review must be undertaken to assess and accommodate changes in the client's current circumstances.

CONTINUE TO SUPPORT PLAN REVIEW | RECOMMEND A NEW ASSESSMENT | CANCEL

6. This will take you to the **CONSENT** screen. Complete the required fields and select **CONTINUE TO SUPPORT PLAN REVIEW**.

Consent to share information with My Health Record

All fields marked with an asterisk (*) are required.

Information

The client can choose to share the support plan from this assessment via their My Health Record if they have an active account. This will allow the support plan to be viewed by whoever has access to view their medical records. This may include healthcare providers, the client's nominated representative(s), and the client themselves. If the client does want this information made available via My Health Record, they must provide informed consent. This is necessary to meet requirements of both the Privacy Act 1988 with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under Chapter 7, Part 2 of the Aged Care Act 2024. If there is a suggestion that the client lacks capacity, this decision can be made in consultation with the client's confirmed representative in My Aged Care.

Does the client consent to share their Support Plan with My Health Record (MHR)? *

☐ No ☒ Yes

Consent decision by *

Client ▼

Comments:

CONTINUE TO SUPPORT PLAN REVIEW
CANCEL

7. A pop-up window will open to input the client's change in circumstance. Select the relevant reason.

Start support plan review for Freddy FLINT

All fields marked with an asterisk (*) are required.

What circumstances have changed for the client? *

Please select...

- Hospital Discharge
- Fall(s) or risk of falling
- Change in medical condition
- Change in cognitive status
- Change in care needs
- Increasing frailty
- Change in caring arrangements
- Change in living arrangements
- Review service recommendations
- Vulnerable client
- Needs Transition Care
- Needs Residential Care
- Needs Residential Respite
- Client has relocated
- Needs End-of-Life Pathway
- Review End-of-Life Pathway
- Review HM tier
- Review AT tier
- Needs Restorative Care

0 / 1000

.jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .txt

START SUPPORT PLAN REVIEW
CANCEL

- Continue to input all the relevant information, **UPLOAD** any supporting documentation (such as a letter from qualified health professionals) as required and select **START SUPPORT PLAN REVIEW**.

Start support plan review for Freddy FLINT

All fields marked with an asterisk (*) are required.

What circumstances have changed for the client? *

Change in care needs ▼

How has this affected the client's need? * ?

Client's day to day routine is impacted due to declining health condition

73 / 1000

Add additional information to support your request? ?

UPLOAD ADDITIONAL INFORMATION1

You can upload files up to 5 MB to this record. The following file types are accepted: .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .txt

START SUPPORT PLAN REVIEW

CANCEL

Transferring a Support Plan Review

Both assessors and team leaders can transfer Support Plan Reviews to other assessment organisations.

- To begin transferring a Support Plan Review, go to **Current reviews** and select the client card you wish to transfer for the Support Plan Review. Select **TRANSFER SUPPORT PLAN REVIEW**.

The screenshot shows the 'Current reviews' section of a web application. On the left, there's a 'Filter by' section with 'Urgency' selected and a 'Not Started' status filter. The main area displays a client card for 'Melina RAMSEY'. The card includes personal details (Female, 84 years old, 30 July 1940), request information (Requested by: Health Professional Admin, Contact: Grayden Jeanbaptiste, Request submitted by: Denese Mahafley, Client last assessed by: Abbey Riedman, Request dates: Date requested: 3 March 2023), and a 'Reason for request' section (Client's change in circumstances: Hospital Discharge, Impact on client's change needs: Harley is requesting Domestic Assistance, Meals, Personal Care & Transport for Milena, because increasing functional decline, back pain and falls at home). At the bottom of the card, there are three buttons: 'VIEW FULL CLIENT RECORD', 'VIEW ALL CLIENT NOTES', and 'VIEW CLIENT REPORT'. Below these, there are two buttons: 'START SUPPORT PLAN REVIEW' and 'TRANSFER SUPPORT PLAN REVIEW'. The 'TRANSFER SUPPORT PLAN REVIEW' button is highlighted with a red box.

- You will need to enter **What is the reason for the transfer** and search and select the Assessment Organisation which the Support Plan Review will be transferred to.

Once the reason for transfer and organisation has been selected, select **TRANSFER** to finalise.

A banner will display at the bottom advising you to call the assessment organisation you are referring the client to. This banner also highlights the need for client consent prior to transferring.

Transfer this support plan review for Melina Ramsey

All fields marked with an asterisk (*) are required.

What is the reason for transfer? *

Comments:

Search for Assessment Organisation: *

☒ Use the client's address

Client address

1000 NICOLE Crescent WODONGA VIC 3690

☐ Enter an alternative assessment address

SEARCH

TRANSFER CANCEL

Before making the transfer, please contact the Assessment Organisation you want to refer the client to and provide as much information as possible in the comments box to assist the receiving organisation. Please note, a review can only be transferred once. Please ensure that you have client consent before transferring.

Accessibility Privacy Disclaimer Terms
Copyright © Commonwealth of Australia

Australian Government
Department of Health

myagedcare

! Support Plan Reviews can only be transferred once.

Support Plan Review for Support at Home

A Support Plan Review for Support at Home is conducted when there is a need to reassess a client's current Support at Home services due to changes in their circumstances, goals, or care needs. This review ensures that the services being provided remain appropriate, effective, and aligned with the client's preferences and situation.

The **Goals & recommendations** tab is where you will record the clients:

- areas of concern,
- goals to address their concerns,
- any services or general recommendations, and
- any care type recommendations.

Identified needs	Client Motivations	Goals & recommendations	Decisions	Manage services & referrals	Associated People	Review
------------------	--------------------	-------------------------	-----------	-----------------------------	-------------------	--------

Support at Home care types are delivered under the *Aged Care Act 2024* (the Act). If they need a delegate decision, this can be done at [Add a care type for delegate decision](#).

Support Plan Review for services following an End-of-Life Pathway episode

Assessors may receive a Support Plan Review (SPR) request for a client who is nearing the end of their End-of-Life pathway episode, or has outlived their End-of-Life (EoL) pathway episode and requires ongoing services.

In this situation the assessor *must* complete an SPR to determine the client's current needs and recommend to either:

- revert to the previous ('latent') SaH classification, or
- conduct a reassessment to allow the client to access a higher ongoing Support at Home classification. (for example, they may have been approved initially for a SaH 4, then accessed EoL, and now need a SaH 8 ongoing which will better support their higher needs).

For clients in this scenario, the SPR request will typically be initiated by the service provider.

The provider will submit the request by selecting **Review End-of-Life Pathway** as the reason when lodging the SPR.

Revert to the previous 'latent' SaH classification

To revert to the previous ('latent') Support at Home classification:

1. Open the SPR request linked to the client's record.

The screenshot shows a digital form for a Support Plan Review (SPR) request. At the top, the client's name 'Princeton MCDONALD' is displayed in white text on a teal background. Below this, the location 'GOROKAN, NSW, 2263' is shown with a location pin icon. Further down, the 'Aged care user ID: AC81636524' is listed. The 'Requested review date: 28 May 2026' and 'Request action date: 7 June 2026' are also visible. At the bottom of the form, there are two status indicators: 'Not Started' with a clock icon on a grey background, and 'Urgent' with a warning triangle icon on a yellow background.

- Review the reason for the request, noting the provider has identified that the client has outlived the End-of-Life Pathway or is close to finishing their 16 weeks of services.

Princeton McDONALD

Aged 92 (14 October 1933), Male

Urgent request
Requested: 28 May 2026 Requested action date: 7 June 2026

Files were attached to this request [View client attachments](#)

Requested by Aged Care Service Provider Adssi In-home Support Contact Rogelio Barker 0486 898 790 Deneen.Hite@test.qylbss.fbf Request submitted by: Rogelio Barker Client last assessed by: Gerson Noland	Reason for request Why is this request urgent? test Clients change in circumstances: Review End-of-Life Pathway Impact on client's needs: gthadbasj Primary reason for request: Request for additional CHSP services for clients who are in receipt of a Support at Home Services client is currently receiving:
---	--

- Go to the client's Goals & Recommendations tab of their Support plan and services page. In the IAT Outcome and Classifications section, an Information banner displays, indicating that the client is currently on the End-of-Life Pathway and can only be recommended for a **Latent or higher ongoing Support at Home classification**.

i Client currently on EOL can only be recommended Latent or Higher Ongoing SAH classification.

Select Revert to **Ongoing SAH Classification** or **Override to Transitioned HCP Classification**.

Revert to Ongoing SAH Classification example

Support plan and services [PRINT COPY OF SUPPORT PLAN](#)

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

IAT Outcome and Classifications

Current assessment type:	Comprehensive Assessment	Existing classification:	SaH Classification 4
IAT Outcome:	SaH Classification 4		
Recommended classification:	SaH End-of-Life Pathway		
	AT Medium		
Override reason:	Higher level service needs		
Override reason description:	EOL test		

[REVERT TO ONGOING SAH CLASSIFICATION](#)

Override to Transitioned HCP Classification example

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals | Associated People | Review

FLAG AS END-OF-LIFE | PRINT COPY OF SUPPORT PLAN

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

Existing classification: Transitioned HCP Level 2 (Pending allocation)
SaH End-of-Life Pathway
AT Medium

Client currently on EOL can only be recommended Latent or Higher Ongoing SAH classification.

Override to Transitioned HCP Classification

4. A pop up appears to confirm the revert or the override. Select **REVERT** or **OVERRIDE** to proceed.

Revert to ongoing SAH Classification pop up example

Revert to ongoing SaH Classification

Revert to ongoing SaH Classification for PGrihana SONDONTUSEGP:

Classification: SaH Classification 4

Classification type: Ongoing

REVERT CANCEL

Override to Transitioned HCP Classification pop up example

Override to Transitioned HCP Classification

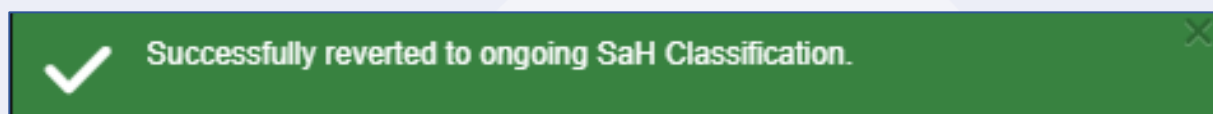
Override current SaH Classification for Hong BLOCK to ongoing Transitioned Classification:

Classification: Transitioned HCP Level 2

Classification type: Ongoing

OVERRIDE CANCEL

5. If successful, a green banner appears at the bottom of the screen.



6. Once overridden, the client's IAT Outcome and Classifications section now shows their latest classification and the override reason of Latent Pending.

Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals | Associated People | Review

FLAG AS END-OF-LIFE | PRINT COPY OF SUPPORT PLAN

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

Recommended classification: Transitioned HCP Level 2

Override reason: Higher level service needs

Override reason description: Latent Pending

Client currently on EOL can only be recommended Latent or Higher Ongoing SAH classification.

REVERT TO END-OF-LIFE

- Finalise the SPR and record the outcome in the system, transitioning the client from the End-of-Life pathway to their 'latent' ongoing Support at Home classification to support continuity of services.

You will be taken to the **Decisions** tab to submit for Delegate decision. Go to the bottom of the page and select **SAVE AND SUBMIT FOR DELEGATE DECISION**.

- The **Submit for Delegate decision** pop up appears. Confirm that the Client applied for care under the Aged Care Act 2024 by selecting the tickbox, then select **SUBMIT**.

- A green banner will then display confirming the assessment and support plan has been sent to the Delegate for their decision.

Reassessment for a new Support at Home Classification following an episode of End of Life

- Go to the Plans tab of the client record, and select **REQUEST A REVIEW** from the top right of the screen.

- The Request a Review page appears. Fill out all mandatory details and add any relevant documentation (such as a care plan).

1800 836 799 Mon-Fri 8am - 8pm Sat 10am - 2pm

Service and Support Portal

Welcome Shonda from Aged Care Group Health & Wellbeing

Home | Client Record | Request a review

Mr UATAUTOMaryami UATAUTOHobartx UATAUTOFAYH (UATAUTOJaycel)
Male, 78 years old, 9 December 1947, AC45229649 (Lot Number 28 SEENEY STREET ZILLMESE, QLD, 4034)

Request a Review

All fields marked with an asterisk (*) are required.

Request details

What circumstances have changed for the client? *

How has this affected the client's needs? *

Does this request need to be actioned urgently? ☐ No ☐ Yes

What type of subsidised aged care is the client receiving? *

☐ Support at Home (Self)
☐ Commonwealth Home Support Programme (CHSP)
☐ Support at Home and Commonwealth Home Support Programme
☐ Flexible Care
☐ Residential Care

Primary reason for Support Plan Review Request *

☐ Request for additional CHSP services for clients who are in receipt of a Support at Home
☐ Request for additional CHSP services or changes to CHSP services for clients who are only receiving CHSP services currently
☐ There is a change in a client's circumstances and they have an immediate need for access to Support at Home services
☐ There is a significant change in the client's needs and additional Aged Care Act 2024 (the Act) based aged care services are required

Please provide a copy of the client's care plan and individualised budget *

Is there any sensitive client information within the attached care plan or individualised budget? *

☐ No ☐ Yes

(The Team Leader will then be required to assign the assessment to a suitable assessor.)

Assign this review for Doloris Carlos

All fields marked with an asterisk (*) are required.

Change support plan review priority?

Urgent

Reason description: *

TEST

Assign to: *

☐ Ellie HUMPHREYS (0 assessments and 0 reviews assigned)
☐ Roderick WILLINGHAM (0 assessments and 0 reviews assigned)
☐ Benji ROOT (0 assessments and 0 reviews assigned)
☐ Aja SCARBROUGH (0 assessments and 0 reviews assigned)
☐ Trenton PADRON (0 assessments and 0 reviews assigned)
☐ Eligh STUTZMAN (0 assessments and 0 reviews assigned)
☐ Juliann MACKLIN (0 assessments and 0 reviews assigned)

- The assessor that is assigned the assessment will need to go to the **Reviews** tile of the Assessor Portal home page, and then the **Not Started** section of the **Current Reviews** page, to find the client.

Home | Reviews

Current reviews

Currently viewing: ABC Outlet

Filter by

Sort by: Urgency In order of: Show urgent reviews first

Current sort order is Urgency 1 to 7 out of 7 matching results

In Progress

Tomasia GUINN
 MARGATE, QLD, 4019
 Agent care user ID: AC 99999999
 Review assigned date: 27 May 2025
 Delegate Decision due by: 29 May 2025

Stacey SMITH
 WOOLBAY, SA, 5575
 Agent care user ID: AC 88888888
 Review assigned date: 13 April 2025
 Delegate Decision due by: 31 May 2025

All SMITH
 BRISBANE CITY, QLD, 4000
 Agent care user ID: AC 77777777
 Review assigned date: 21 April 2025
 Delegate Decision due by: 30 May 2025

Not Started

Dolores CARLOS
 BLACKBURN VIC 3130
 Agent care user ID: AC 55555555
 Review assigned date: 29 May 2025
 Finalised Support Plan Review due by: 18 January 2025

Home Support Urgent - 506 days overdue

Not Started

- The client's card appears. Select **START SUPPORT PLAN REVIEW**.

Dolores CARLOS

Male, 67 years old, 5 March 1959

Requested by
Representative

Contact:
Sharla Mccord
02 5126 2980

Request submitted by: Landon Greenfield

Request dates
Date requested: 4 January 2025

Finalised Support Plan Review due by 18 January 2025

Reason for request
Client's change in circumstances:
Change in care needs

Impact on client's change needs:
Thaer Jamoaa needs Assessment because He is struggling to find a provider who has staff that can speak Arabic. He wants home care package. He had lower back surgery and can't walk distances. He use a walking stick. The client requires an Aged Care Assessment.

[VIEW FULL CLIENT RECORD](#) [VIEW ALL CLIENT NOTES](#) [VIEW CLIENT REPORT](#)

[START SUPPORT PLAN REVIEW](#) [FLAG AS END-OF-LIFE](#) [TRANSFER SUPPORT PLAN REVIEW](#)

5. The 'Before you start the Support Plan Review' pop up appears. Select **RECOMMEND A NEW ASSESSMENT**.

Before you start the Support Plan Review

All fields marked with an asterisk (*) are required.

If the client's circumstances have changed to any of these scenarios from their initial Support Plan:

- Needs Transition care; or
- Needs Residential care; or
- Needs Residential respite; or
- Client has relocated; or
- Needs End-of-Life Pathway (if not ongoing SaH client); or
- Needs services after End-of-Life Pathway (if not ongoing SaH client); or**
- Needs Assistive Technology or Home Modification services (if not AT or HM in place); or
- Needs a new or different SaH classification; or
- Needs CHSP classification; or
- Needs Restorative care Pathway; or
- Needs services after Restorative Care Pathway

you have the option to "Recommend a New Assessment" instead of Support Plan Review.

Otherwise, a Support Plan Review must be undertaken to assess and accommodate changes in the client's current circumstances.

CONTINUE TO SUPPORT PLAN REVIEW

RECOMMEND A NEW ASSESSMENT

CANCEL

6. The assessor will then press **START TRIAGE** and then continue to **START ASSESSMENT**, after Triage is completed.

Start Triage

Doloris CARLOS

Assessor	Kesha Day
Support plan review	2 June 2026
Support plan	14 November 2019
Comprehensive Assessment	2 June 2026
Comprehensive Assessment	18 August 2025
Comprehensive Assessment	27 July 2023
Home Support Assessment	9 January 2023

dogs were spent and the grub was getting lowAnd on I went though the dogs were spent and the grub was getting lowAnd on I went though the dogs were spent and the grub was getting lowAnd on I went though the dogs were spent and the grub was getting lowAnd on I went though the dogs

04/03/2025

And greasy smoke in an inky cloak went streaking across the sky DC7BB101936 And every day that quiet clay seemed to heavy and heavier growAnd every day that quiet clay seemed to hea

VIEW ALL 10 CLIENT NOTES

Comments

TEST

Cohabitant details

[Kimiko CORTEZ](#)

[Tania HUFFMAN](#)

VIEW FULL CLIENT RECORD

VIEW CLIENT REPORT

START TRIAGE

ASSIGN TO TRIAGE DELEGATE

REFER URGENT SERVICES

Start Assessment

Doloris CARLOS

Assessor: Keshia Day
Triage conducted by: Keshia Day

Support plan: Triage Completed
Comprehensive Assessment: Triage Completed

04/03/2025
And greasy smoke in an inky cloak went streaking across the sky
DC7EB101936 And every day that quiet clay seemed to heavy and heavier
growAnd every day that quiet clay seemed to hea

VIEW ALL 10 CLIENT NOTES

Comments
TEST

Cohabitant details
[Kimiko CORTEZ](#)
[Tania HUFFMAN](#)

VIEW FULL CLIENT RECORD VIEW CLIENT REPORT
REFER URGENT SERVICES **START ASSESSMENT** FLAG AS END-OF-LIFE

7. After the assessment is finished, select **FINALISE IAT**.

Finalise IAT and go to support plan

Once you select 'Finalise IAT', you cannot make any changes to the responses in this questionnaire, and you will be taken to the Support Plan. Once the IAT is finalised, the system will determine the outcome of the assessment, which can be viewed in the Support Plan.

If you wish to continue with the Support Plan, please select 'Finalise IAT' or if you wish to make any changes to the questionnaire, please select 'Take me back to the assessment'.

FINALISE IAT TAKE ME BACK TO THE ASSESSMENT

8. The IAT outcome from the re-assessment will appear in the **Goals & Recommendations** tab. An Information message displays that the client can only be recommended their latent or a higher ongoing classification level.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

GO TO THE ASSESSMENT FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
IAT Outcome: SAH Classification 7
Existing classification: Transitioned HCP Level 4
SAH End-of-Life Pathway
AT Medium

Client currently on EOL, can only be recommended Latent or Higher Ongoing SAH classification.

ACCEPT OVERRIDE

9. The assessor will then accept the new SAH Classification, complete the assessment and support plan as per normal processes prior to submitting for delegation.

Support plan and services

Identified needs **Goals & recommendations** Decisions Manage services & referrals Associated People Review

GO TO THE ASSESSMENT FLAG AS END-OF-LIFE PRINT COPY OF SUPPORT PLAN

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
IAT Outcome: SAH Classification 7
Existing classification: Transitioned HCP Level 4
SAH End-of-Life Pathway
AT Medium

Client currently on EOL, can only be recommended Latent or Higher Ongoing SAH classification.

ACCEPT OVERRIDE

Client concerns and goals

ADD AREA OF CONCERN

Concern:
Sasha I got frustrated I had no theories about bringing up SAS233953

ADD A GOAL

Goal: I would like to get help that assists me to stay at home.

Concern:
And at night the wondrous glory of the twinkling stars what an awesome + DNF14845

ADD A GOAL

Goal: I can access respite care when I need it.