

Aged Care Assessment Manual

Version 8.4

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IMPORTANT

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

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

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

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

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Document purpose

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

In addition to the guidance in this manual, assessors are expected to also use the Aged Care Assessment Quality Framework to deliver a high-quality assessment experience and service for every older person. All assessors, delegates and team leaders are also required to complete the mandatory training outlined in the My Aged Care Workforce Learning Strategy v1.5.

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

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

Key sources of information to complement this manual include:

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

Terminology

Throughout this document:

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



This symbol displays throughout the document and denotes significant change in information and the assessment process from version 8.3 of the Aged Care Assessment Manual.



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

Document Structure

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
Chapter 1 *Aged Care Act 2024*	Key concepts under the *Aged Care Act 2024* that are important to understand. Eligibility requirements to access aged care services Service list and structure under *Aged Care Rules 2025* Approvals under *Aged Care Act 2024* Transition arrangements	Minor change (section 1.4.2) to guidance around individuals aged 50 – 64 who are approved for aged care services being also eligible for reassessments at a later date.
Chapter 2 Overview of My Aged Care and Single Assessment System	Provides information about My Aged Care and the Single Assessment System including: • Introduction of pilot of Aboriginal and Torres Strait Islander Assessment Organisations from August 2025 • Assessment Organisation roles and responsibilities • Assessment types • The Integrated Assessment Tool (IAT)	No changes made to this Chapter.
Chapter 3 Referral, Registration and Screening	Details the referral, registration and screening stages of the assessment journey. Information includes: • Registered supporters • Entry into My Aged Care • Registering with My Aged Care • Screening • Alternative entry (urgent services pathway)	Minor changes to guidance regarding CHSP direct-to-provider referrals (3.2.1). Additional clarifications regarding the process for submitting the *Emergency Residential Care - Application for Care Form* (Section 3.2.; 3.2.2). Additional clarification to guidance for Emergency Residential Care extension applications to specify 5 calendar days (Section 3.6.1).

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
	• Application for Care form	
Chapter 4 Referral for Assessment	Details the assessment referral process in the My Aged Care assessor portal including: • Managing and actioning referrals and assigning referral priority • Managing preference for Aboriginal and Torres Strait Islander assessments • Explaining how priority categories are assigned to different assessments including Home Support, Comprehensive and Hospital Assessments • Using the End-of-Life Pathway 'high priority' referrals in the system • Explaining how assessors can self-refer for eligible and (likely) ineligible individuals. • SPRs and reassessment requests	Minor changes to guidance around the process for rejecting a referral and the best practice for contacting clients via telephone (Section 4.3.8).
Chapter 5 Assessment Activities	Includes important information about how to undertake an aged care needs assessment and complete a support plan for an older person. This chapter includes: • Consent for triage and assessment • Triaging Assessments and Triage Delegate role • Triage for SPRs • Revocation of Eligibility • Undertaking a needs assessment using the IAT • Assessment settings	Additional guidance regarding considerations to support an older person provide consent (Section 5.1). Additional guidance regarding assessment eligibility for individuals approved under the homelessness and risk of homelessness criteria (Section 5.2.3). Minor changes to support networks available for triage delegates to refer to for older people who are more vulnerable or hesitant to participate (Section 5.3.1).

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
	• Clinical attendance • IAT Outcome • Recommending service types and services • Converting a home support assessment to comprehensive • Support Plan • Wellness & Reablement • Linking Supports • Assessment wrap-up	Additional guidance regarding interactions between TCP and ongoing home support services (5.7.7). Additional guidance on managing End-of-Life (EoL) clients where the IAT outcome is CHSP (Section 5.7.7). Minor change to 'Risk of Vulnerability Cohort' options (Section 5.10.2).
Chapter 6 Aged Care Programs	Includes important information about the aged care programs recommended by assessors to meet an older person's needs and goals.	Minor changes to eligibility criteria to receive Restorative Care Pathway (Section 6.2.1). Updated guidance on accessing Restorative Care Pathway within the take-up period (Section 6.2.5). Removed advice on transitional Short Term Restorative Care as all transitional episodes have since been completed (Section 6.2.6). Updated guidance on accessing additional restorative care funding eligibility and process (Section 6.2.7). Updated guidance on accessing EoL pathway within the take-up period (Section 6.3.2). Minor changes to Table 26 CHSP to remove reference to another table, as that no longer provides further information (Section 6.3.3). Additional guidance on managing EoL clients where the IAT outcome is CHSP (Section 6.3.7).

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
		Minor changes to AT-HM overview (Section 6.4). Updated guidance regarding MND and priority access to AT-HM funding (Section 6.4.10). Minor updates to include reference to CHSP extension to June 2029 (Section 6.5). Minor changes to guidance on urgent service referrals under CHSP (Section 6.5.2). Minor changes to AT-HM under CHSP guidance (Section 6.5.4). Additional clarification on circumstances where SaH participants can access CHSP services (Section 6.5.5). Updated guidance on accessing CHSP services for participants waiting for a SaH place allocation (Section 6.5.5). Updated guidance for clients who require TCP without any ongoing home support services (Section 8.6.3). Updated guidance on interaction between Support at Home and Residential Care (Section 6.9.5).
Chapter 7 Delegations and approvals under the Act	Includes information about: • The powers under the Aged Care Act 2024 that are delegated to Triage Delegates and Clinical and Non-Clinical Assessment Delegates.	Minor changes to AT-HM scheme to include consideration for moderate mobility impairment or moderate risk to a person's health (Section 7.9.2).

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
	• How approvals work under the Aged Care Act 2024, and the decisions that delegates make.	
Chapter 8 Delegate decisions in practice	Includes guidance for assessment delegates covering: • How to make sound, evidence-based decisions • step-by-step processes for approving aged care services across the service groups • Other approvals (including giving approvals after a service has commenced and approving a service without an assessment).	Minor updates to assessment delegate actions in maintaining accuracy and consistency in practice (Section 8.2). Updated guidance regarding amendments process (Section 8.2.5). Minor change to approving CHSP services alongside SaH guidance (Section 8.3.2). Updated guidance regarding decision and selection of all appropriate service types and services (Section 8.3.3). Minor updates to priority category guidance to include MND Priority (section 8.4.3). Updated guidance around approving AT-HM under CHSP (section 8.5.1; 8.5.3). Updated guidance around changes to the way referrals should be made for Specialised Support Services (SSS) for CHSP (section 8.5.4). Minor amendments regarding the process for both the *Emergency Residential Care - Application for Care Form* and extension requests (Section 8.2.6; 8.9.1)
Chapter 9 Finalising the Assessment and Service Referral	Includes guidance about: • Finalising the assessment • Recording and communicating the assessment outcome • Referring the older person for services,	Additional clarification regarding how assessors should refer for CHSP and include referral codes for *all* relevant service sub-types, not just at the service *type* level (section 9.4.5).

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
	• The single provider model for Support at Home (which includes a single referral code for all services/pathways) • Completing the Notice of Decision (approval/non-approval letter).	Additional clarification regarding reissuing CHSP referrals following accessing urgent services (Section 9.4.5).
Chapter 10 SPRs and Reassessments	Includes guidance on the circumstances for conducting a support plan review (SPR) or a reassessment for each aged care program.	Minor clarification regarding reassessments indications where a person is seeking CHSP services alone (Section 10.1). Updated guidance around SPR documentation and contact expectations in SPR process (Section 10.1.1; 10.1.2). Updated guidance around SPRs for AT-HM (Section 10.1.7). Removed advice on transitional Short Term Restorative Care as all transitional episodes have since been completed (Section 10.1.8).
Chapter 11 Reviewable Decisions, Revocations and Complaints	Provides information on assessment related reviewable decisions in accordance with the *Aged Care Act 2024*. It also details: • The Review of Decisions process • Options for reviews and revocations • The complaints process.	No changes made to this chapter.
Chapter 12 Supporting Diverse Experiences and Needs	Outlines the ways in which the aged care system supports an older person's diverse needs by ensuring they have access to person-centred aged care assessments and services. This includes valuing older people, their identities, cultures,	No changes made to this chapter.

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
	abilities, diversity, beliefs and life experiences.	
Chapter 13 Operating Procedures	Includes information on privacy, information management and relevant legislation. Also included in this chapter is information about: • Applying to be a delegate • Clinical governance • Separation of assessment services and delivery of aged care services • Information management and privacy under the Aged Care Act 2024 • Framework for governance of Indigenous data • Branding • Resources for consumers • Reporting and performance	No changes made to this chapter.
Chapter 14 Fees and Payments	Provides guidance on fees, payments and participant contributions for funded aged care services.	No changes made to this chapter.
Appendices	Appendices include: • Glossary • Contact Details • Clinical Governance Guidance for Aged Care Needs Assessment Organisations • Clinical attendance • Wellness and Reablement • Restorative Care Case Studies	Additional guidance for Clinical Assessment Delegate and Aged Care Needs Assessment Team Leaders minimum qualification requirements to include exceptions in certain circumstances (APPENDIX F). Additional guidance regarding amendments process and completing the Amendments Notes Template (APPENDIX H).

Chapter	What you'll find in this chapter	Key Changes from v8.3 to v8.4
	• Aged Care Assessment Workforce Credentials • Case studies of individuals experiencing homelessness or at risk of homelessness • IAT amendment guidance	

1. Chapter 1: Aged Care Act 2024

What you'll find in this chapter

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

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

1.1. About the Aged Care Act 2024

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

The Act upholds these rights through:

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

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

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

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

Chapter 1 – Introduction
This Chapter establishes the purpose, objectives, and scope of the Act. It introduces the key principles that underpin the Act, including the Statement of Rights and the Statement of Principles, which recognise the rights, dignity, and autonomy of older Australians. The Chapter also defines important concepts and terminology used throughout the Act, ensuring consistency in interpretation and application. This Chapter also includes the aged care service list (Prescribed in the *Aged Care Rules 2025* in Part 3).

Chapter 2 – Entry to the Australian Aged Care System

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

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

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

Chapter 4 – Funding of aged care services

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

Chapter 5 – Governance of the aged care system

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

Chapter 6 – Regulatory mechanisms

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

Chapter 7 – Information management

This Chapter establishes the rules for handling aged care data, privacy, and information sharing. It sets out record-keeping requirements for providers and government agencies and outlines protections against the misuse of sensitive personal information. The Chapter also introduces whistleblower protections and mechanisms for publishing key information about aged care providers and services, ensuring transparency and public trust in the system.

Chapter 8 – Miscellaneous

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

Subordinate legislation

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

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

1.2. Statement of Rights and Principles

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

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

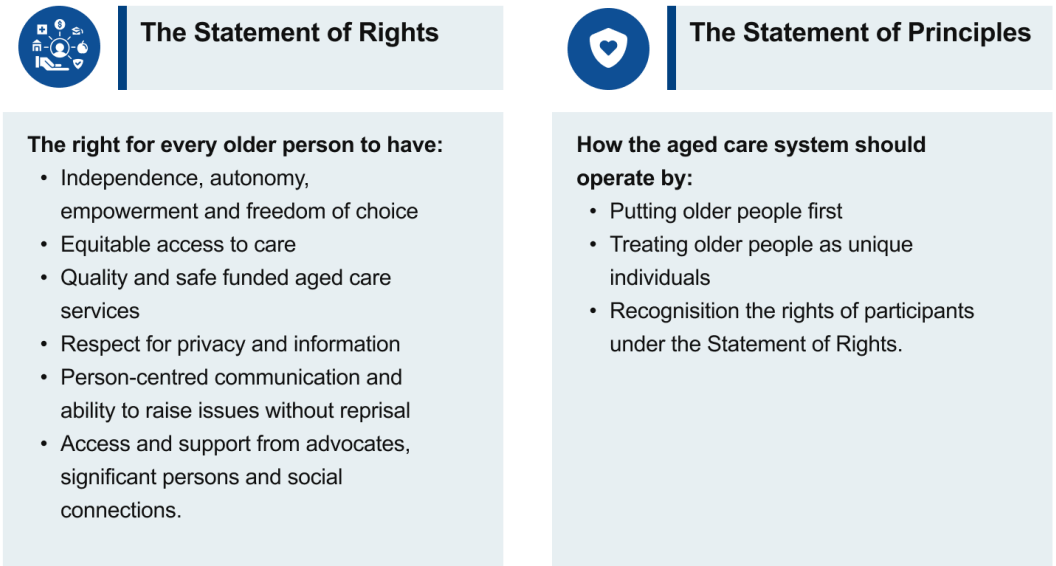


Figure 1 – Aged Care Act 2024 (Cth) Statement of Rights and Principles

1.2.1. The Statement of Rights

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

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

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

1.2.2. The Statement of Principles

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

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

1.3. Dignity of risk

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

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

1.4. Eligibility requirements to access government funded aged care services

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

This means that all services are Act-based services under the Act from 1 November 2025, including services that an older person accesses through a specialist aged care program

(e.g. Commonwealth Home Support Program, Multi-purpose Service Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program and Transition Care Program).

1.4.1. Age eligibility requirements

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

> Note:
>
> To be eligible for an aged care needs assessment an individual must be:
>
> ○ aged 65 or over; or
>
> ○ an Aboriginal or Torres Strait Islander person and is aged at least 50; or
>
> ○ homeless, or at risk of homelessness, and is aged at least 50; and
>
> Each of the above individuals must also provide information relating to the individual's care needs. Care needs are defined under the Act as one or both of the following:
>
> ○ the individual has difficulty (whether physically, mentally or socially) undertaking any daily living activities;
>
> ○ the individual needs help from another person, or the assistance of an aid, to maintain their physical, mental or social capacity to function independently.

1.4.2. Informing the eligible younger person of other services

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

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

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

Note:

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

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

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

Homeless definition

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

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

At risk of homelessness definition

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

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

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

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

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

> Note:
>
> If an individual has an aged care needs assessment between the ages of 50 and 64 years under the homelessness and risk of homelessness eligibility criteria, and is approved for aged care services, they are eligible for reassessment at a later date before turning 65, regardless of whether this eligibility criteria still applies.

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

As part of the commencement of the *Aged Care Act 2024 (the Act)* on 1 November 2025, different transitional arrangements have been put in place for existing clients and new clients being assessed as eligible for government funded aged care services.

Assessment staff should follow the procedures outlined in Table 1 when managing approvals for older people who transitioned from the *Aged Care Act 1997* to the *Aged Care Act 2024*.

Table 1: Transitional Arrangements from 1 November 2025

Cohort	Transitional Arrangements from 1 November 2025
Home Care Package (HCP)	• All HCP recipients transitioned to Support at Home. - Assigned one of four Transitioned HCP classifications based on their current HCP level. • No Support at Home classification (Levels 1–8) assigned at transition. • Transitional classification can be retained indefinitely, even after reassessment, if more beneficial.
Multi-Purpose Services	• Home/community services recipients (or those starting within 3 months) automatically approved for: - Ongoing/short-term home support

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

Cohort	Transitional Arrangements from 1 November 2025
Program (MPSP)	- Assistive Technology (AT) - Home Modifications (HM) • Residential aged care recipients (or those starting within 3 months) approved for ongoing/short-term residential care.
NATSIFACP	• Individuals receiving NATSIFACP services in the 12 months before 1 Nov 2025 are automatically eligible under the Act. • No new assessment required unless care needs change. • All new clients post 1 November are required to make an application for funded aged care services by registering with My Aged Care, undergo a needs assessment and obtain an access approval for one or more service groups in place to access services delivered under NATSIFACP. • However, they can receive NATSIFACP services before assessment if they meet the criteria for alternative entry.
Commonwealth Home Support Program (CHSP)	• Registered and assessed clients automatically transition and continue accessing services. • Unregistered and unassessed clients must have been assessed by 31 October 2025 to continue accessing services. • Grandfathered clients (from pre-2015 programs) who have never been assessed must undergo an assessment. • Under the transitional arrangements and under section 71 of the Act, CHSP clients who have accessed a CHSP service by 31 October 2025 and are awaiting assessment on or after 1 November can have their service approval backdated to 1 November if they are found eligible at assessment
Short-Term Restorative Care (STRC) ***(now known as Restorative Care Pathway RCP)***	• The STRC Programme changed to the 'Restorative Care Pathway' under Support at Home from 1 November 2025. Transition arrangements applied to two cohorts: ○ Participants who commenced their STRC care episode before 1 November 2025 and were still in progress on that date continued their care under transitional arrangements. ○ Participants approved for the STRC Programme who commenced their care on or after 1 November 2025 had their approval converted to the Restorative Care Pathway (RCP), with six months from the date of STRC approval to accept their RCP/AT-HM place. • All STRC approvals have now either concluded or transitioned to RCP.

Cohort	Transitional Arrangements from 1 November 2025
	• If participants did not access their approval within the six-month period, they will need to be reassessed to access restorative care or AT-HM under the Support at Home program, if eligible
Younger People	• Younger people already accessing services on 1 November 2025 did not require a reassessment. • Younger people currently accessing services will be able to continue to access these services and also be eligible to be assessed for other aged care services in the future. • Younger people, who were in the process of applying for aged care services on 1 November, will be eligible to be assessed under relevant criteria within the *Approval of Care Recipients Principles 2014*.
Transition Care Program (TCP)	• Transition Care Program clients who continued to receive care across the transition from the *Aged Care Act 1997* to the *Aged Care Act 2024* had their eligibility and approval deemed across. • All new clients post 1 November 2025 are required to have a comprehensive assessment and receive delegate approval, before they are discharged from hospital, to be referred to a transition care service provider.
Residential Care	• Existing residents in care on 1 November 2025 were allocated a place to ensure no payment or continuity of care issues for the provider or older Australian. This cohort of older Australians did not need to do anything to facilitate this allocation. It happened as part of the transition to the Act. • Older Australians who were assessed and approved as requiring residential care, prior to 1 November 2025, were automatically allocated a place and can enter care when they choose to.

1.5.1. Transitioned Home Care Package

All individuals who were receiving a Home Care Package (HCP) on 1 November 2025 were transitioned to the Support at Home program. At the point of transition, they were not assigned a Support at Home classification level (Levels 1–8). Instead, each person was allocated one of four Transitioned Home Care Package classifications, based on their HCP level prior to 1 November 2025.

Clients can remain on these transitional classifications indefinitely, unless assessed and approved for a Support at Home classification at a higher level. A transitional classification can be retained even if the client has a new assessment and the IAT Outcome results in a

Support at Home classification level that would reduce their funding compared to their transitional level. When reassessing transitioned clients, assessors must ensure the transitional classification is retained when it is more beneficial to the client.

Table 2: Transitioned levels and recommended outcomes

Transition level	IAT Outcome	Recommended outcome
Transitioned HCP 1	CHSP Support at Home Classification 1	Retain Transitioned HCP 1
	Support at Home Classification 2-8	Use Support at Home 2-8 Class aligning with IAT Outcome.
Transitioned HCP 2	CHSP Support at Home Classification 1-2	Retain Transitioned HCP 2
	Support at Home Classification 3-8	Use Support at Home 3-8 Class aligning with IAT Outcome.
Transitioned HCP 3	CHSP Support at Home Classification 1-5	Retain Transitioned HCP 3
	Support at Home Classification 6-8	Use Support at Home 6-8 Class aligning with IAT Outcome.
Transitioned HCP 4	CHSP Support at Home Classification 1-7	Retain Transitioned HCP 4
	Support at Home Classification 8	Use Support at Home 8 Class aligning with IAT Outcome.

Section 6.7 Classification of the Support at Home Manual.

1.5.2. Support plan reviews for transitioned Home Care Package (HCP) clients

Transitioned HCP clients will continue to be eligible for support plan reviews (SPRs) under the same process currently in place. However, in line with existing procedures, if it is determined that a client's circumstances have changed significantly, a reassessment will be required.

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

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

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

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

If a transitioned HCP recipient has no HCP unspent funds and requires AT-HM, the provider can, with consent from the participant, refer them for a support plan review.

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

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



AT-HM List

1.5.4. Multi-Purpose Service Program (MPSP)

Existing MPSP clients on 1 November 2025

Transitional arrangements were put in place for individuals already accessing services under the MPSP on 1 November 2025 to provide for service continuity.

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

An individual accessing aged care services in a home or community setting through a MPSP provider at transition time, or who has an agreement in place to commence these services within 3 months of the transition time, will be approved for ongoing and short-term home support, as well as short-term AT and HM.

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

> Note:
>
> An individual's transitional status is confirmed by a notice given to the client, via their MPSP provider. This notice is also attached to their My Aged Care Client Record. By July 2026, relevant approvals and referrals will also be retrospectively added to Department of Health, Disability and Ageing systems to facilitate these individuals moving between MPSP and mainstream services in future.
>
> If an older person in one of the transitional cohorts above wants to access mainstream aged care services (outside the MPSP):
>
> if they plan to access mainstream services under a home and community setting: they will need to call My Aged Care and either:
>
> ○ seek to undergo a re-assessment if they only have a MPSP classification level provided at transition time, or
>
> ○ where they already have a transitional HCP classification level, indicate that they are now seeking mainstream services, where they already have a transitional HCP classification level, at which point they will be placed in the Support at Home Priority System's queue based on their priority category and approval date.

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

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

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

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

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

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

Note:

For clients who have been assessed and want to leave their MPSP provider and access mainstream aged care services:

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

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

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

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

Existing NATSIFACP clients

There are transitional arrangements in place for individuals who accessed services under the NATSIFACP in the 12 months leading up to 1 November 2025 to ensure service continuity with the commencement of the *Aged Care Act 2024* (the Act).

Individuals assessed as falling within the transitional cohorts outlined in the transitional legislation (based on previous needs assessments or information collected from their providers via the six-monthly Service Activity Reports) were deemed to have relevant service

group approvals, and related decisions, in place, as required in order to access funded aged care services under the Act.

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

Note:

Individuals were notified of their status post 1 November 2025 in writing via a notice given to their provider. This letter was updated to their My Aged Care Client Record in late 2025. Relevant service recommendations and referrals have been added to Department of Health, Disability and Ageing's systems.

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

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

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

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

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

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

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

1.5.7. Commonwealth Home Support Program (CHSP)

Assessed Commonwealth Home Support Program (CHSP) clients automatically transitioned under the Act on 1 November 2025. These clients can continue accessing their current CHSP services in line with their assessed need, without taking any action.

Unregistered and unassessed CHSP clients must register with My Aged Care and be assessed as eligible for the CHSP to continue accessing government funded aged care services.

Note:

Assessment approvals can be backdated for eligible CHSP clients under Section 71 of the Act.

Transitional rules allow CHSP clients who applied for an assessment by 31 October to have approvals backdated to 1 November if they are assessed as eligible after the Act commenced.

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

1.5.8. Short-Term Restorative Care (STRC) Programme

The Short-Term Restorative Care (STRC) Programme has changed to the 'Restorative Care Pathway' under Support at Home. Transition arrangements applied to two cohorts:

- Participants who commenced their STRC care episode before 1 November 2025 and were still in progress on that date continued their care under transitional arrangements.
- Participants approved for the STRC Programme who commenced their care on or after 1 November 2025 had their approval converted to the Restorative Care Pathway (RCP), with six months from the date of STRC approval to accept their RCP/AT-HM place.

All STRC approvals have now either concluded or transitioned to RCP.

If participants did not access their approval within the six-month period, they will need to be reassessed to access restorative care or AT-HM under the Support at Home program, if eligible.



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

1.5.9. Transition Care Program (TCP)

TCP clients receiving transition care on 1 November 2025

Transition Care Program clients in care on 1 November 2025 had their eligibility and approval for the program deemed across.

New TCP clients post 1 November 2025

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

1.5.10. Residential Care

Residential care clients in residential care on 1 November 2025

Residents in care on 1 November 2025 were allocated a place to ensure no payment or continuity of care issues for the provider or older Australian. This cohort of older Australians did not need to do anything to facilitate this allocation.

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

Older Australians who were assessed and approved as requiring residential care, prior to 1 November 2025, were automatically allocated a place on commencement of the *Aged Care Act 2024* and can enter care when they choose to.

1.5.11. Younger People

Younger people receiving existing aged care services

On commencement of the *Aged Care Act 2024* (the Act) on 1 November 2025, any younger individual[2] already accessing services are not required to have a reassessment. Younger individuals will be able to continue to access services, even if they are below the minimum age requirements for the Act, subject to any actions required for that individual to transition to the Act.

If the care needs of younger individuals, who transitioned from the *Aged Care Act 1997*, have changed, they will be eligible for reassessment to access residential aged care. These individuals may be eligible for reassessment for other aged care services based on program level transition rules.

Younger people with 'In-flight assessments'

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

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

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

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

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

Since 1 November 2025, if a person aged under 65 (who is not Aboriginal and Torres Strait Islander, homeless or at risk of homelessness and aged 50+) has not commenced the process of applying for aged care services (including registering with AFA or the NDIA YPIRAC team), they are not eligible for an assessment for aged care services.

1.6. Aged Care Service List

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

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

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

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

The Aged Care Service List serves several key functions:

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

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

1.7. Service groups

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

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

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

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

Note:

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

1.8. Approvals under the *Aged Care Act 2024*

Approvals under the *Aged Care Act 2024* revolve around three primary components that, when combined, are comparable to 'being approved for a program' under the *Aged Care Act 1997*. The components are 'Service group,' 'Classification type' and 'Classification level' (sometimes simply referred to as 'Classification'). A priority category is also applied in some circumstances.

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

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

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

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

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

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

Table 5: Service group: Home support

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

Table 6: Service group: Assistive technology

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

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

Table 7: Service group: Home modifications

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

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

Table 8: Service group: Residential care

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

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

1.9. Deciding if the older person requires aged care services

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

This decision is made based on:

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

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

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

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

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

Important:

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

1.9.1. Approvals for service types and services

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



See Chapter 7: Delegations and approvals under the Act for further information on service approvals.

1.9.2. Approvals for priority categories

The priority categories assigned to individuals under section 86 of the Act determine when certain services are allocated under section 92 of the Act. These categories are based on the assessed urgency of need, complexity of care requirements, and potential risks associated with delayed support.



See Chapter 7: Delegations and approvals under the Act for further information on priority category decisions.

1.9.3. Period of effect of approvals

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

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

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

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



See Chapter 7: Delegations and approvals under the Act for further information on period of effect of approvals.

1.10. Accessing funded aged care services

Under the Act, older people will access funded aged care services through the following:

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

Note:

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

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

1.11. Where approvals can be used

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

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

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

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

The systems, tools and templates assessors and assessment delegates use will take these into account and/or prompt when needed.

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

Program	Service group – Classification type - Classification level
Commonwealth Home Support Program (CHSP)	Home support – ongoing - CHSP class Assistive technology – short-term – AT CHSP Home modifications – short-term – HM CHSP
Support at Home program	Home support – ongoing – SAH class 1 to 8 Home support – short-term – SAH restorative care pathway Home support – short-term – SAH end-of-life pathway

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

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

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

What you'll find in this chapter

This chapter provides information on the Single Assessment System including:

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

2.1. My Aged Care

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

The key elements of My Aged Care include:

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

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

- a central older person record that will include each older person's current aged care requirements and associated history and services provided through My Aged Care
- ability to request, register and end registered supporter relationships

- a referral capability that enables the contact centre, ACSOs and assessors to find appropriate assessment, home support, residential and community support services or resources for older people

- web-based portals for older people (My Aged Care Online Account), assessors, service providers and support organisations.

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

- manage their assessment organisation contact details and set up individual staff members with access to the My Aged Care assessor portal

- manage referrals for assessment

- submit and action requests to create, to register or end supporter relationships and create organisation agent relationships

- complete triage and determine eligibility for an aged care needs assessment

- undertake assessments using the IAT and develop a Support Plan

- make delegate decisions for access to government-funded aged care services

- conduct support plan reviews (SPRs) and reassessments

- refer older people for aged care services

- recommend a period of reablement or for linking support on the Support Plan

- review and update older person records consistent with the assessment and Support Plan outcomes.

My Aged Care is committed to supporting older Aboriginal and Torres Strait Islander people and their carers by making it easier to access aged care assessment services that are respectful of culture, community, and connection to Country. All assessment organisations, including those participating in the Aboriginal and Torres Strait Islander assessment organisations pilot, recognise the importance of cultural safety, trust, and relationships. Embedding cultural safety into the assessment process will help improve the experience of older Aboriginal and Torres Strait Islander people, as well as their families and carers. Information, assessment and support will be delivered in ways that uphold dignity and promote wellbeing.

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

Older Aboriginal and Torres Strait Islander people can indicate their preference to have their assessment delivered by an Aboriginal and Torres Strait Islander assessment organisation where one operates in their area.

A client's preference to be assessed by an Aboriginal and Torres Strait Islander organisation can be captured at multiple points along the aged care journey. It may be

captured when registering a client in the My Aged Care system, confirmed when completing demographic details during the triage stage of an assessment. It may also be noted by an assessor during an assessment. Once recorded, the preference will display in the client's profile and on the client's card.

It is acknowledged that establishing trust may require time, particularly for older Aboriginal and Torres Strait Islander people. Assessors should ensure clients feel culturally safe, respected, and comfortable before they request personal or sensitive information. To support this, assessors should consider if assessments should be conducted over multiple sittings to allow the process to proceed at a pace that respects the older person's readiness and preferences. During this period, assessors are expected to maintain regular contact with the older person while the assessment remains active. This ongoing engagement helps foster trust and continuity and ensures that the older person feels supported throughout the process.

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

2.2. Single Assessment System

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

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

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

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

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

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

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

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

2.3. Aboriginal and Torres Strait Islander assessment organisations

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

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

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

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

These organisations provide older Aboriginal and Torres Strait Islander people:

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

Aboriginal and Torres Strait Islander assessment organisations work closely with local community organisations and support networks including Aboriginal Community Controlled Organisations, Aboriginal Community Controlled Health Organisations, and the Elder Care Support program. Together, they work to support, empower, educate and

encourage the older Aboriginal and Torres Strait Islander people and their communities to identify their needs and explore how aged care can help them age well, remain connected to community, and support them to stay at home and on Country for longer.

Older Aboriginal and Torres Strait Islander people can access aged care needs assessments through the existing assessment organisations, or once established, through an Aboriginal and Torres Strait Islander assessment organisation if available in their area.

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

Aboriginal and Torres Strait Islander assessment organisations are expected to:

- conduct culturally safe, trauma aware and healing informed assessments using yarning and flexible approaches to build trust with the older Aboriginal and Torres Strait Islander person. Assessments may be delivered at a location that the older person feel most at ease and comfortable

- undertake face-to-face assessments, where possible. This could be in the older person's home, at a community centre, or outdoors at a place of the older person's choosing

- allow for multiple visits, if required, to build trust and develop a relationship

- with client's consent, involve the client's family members, advocates, registered supporter/s or other people who support the client in the assessment process with the client's consent and/or in line with the client's will and preferences

- connect with the older person's GP, service provider and support networks to help inform an assessment, to gain a comprehensive understanding of the client's health and wellbeing, minimising the older person having to tell their story multiple times

- be embedded within the local community. Connecting with the local community with their knowledge of local services, customs and protocols will allow them to support matching appropriate assessors to the older people preferences and needs

- maintain a connection with the older person for the whole journey through to receiving services via assessors and/or Elder Care Support workers. This will help to manage any uncertainty or questions throughout the process

- work with organisations that support stolen generation survivors and their families

- provide interpreting services, when needed, and

- support clients to access services they need (where this cannot be provided by ECS workers or care finders)

- Single Assessment System for aged care | Australian Government Department of Health, Disability and Ageing
- Aboriginal and Torres Strait Islander Assessment Organisations
- Interactive map of available services
- Fact Sheet for assessors

2.4. Overview of assessment organisation roles and responsibilities

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

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

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

For further information on the qualifications required to hold the roles in the below table, please refer to Appendix F. Refer to the My Aged Care Workforce Learning Strategy v1.5 for the training requirements for the roles specified below.

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

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

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

Role Title	Role type	Role Description
		clinical assessment delegate System role to exercise the Assessor Portal functions).
Non-clinical assessor	Business and System	A non-clinical needs assessor undertakes home support assessments in accordance with Chapter 5 of the Aged Care Assessment Manual. A non-clinical aged care needs assessor also holds the role of non-clinical assessment delegate under the Instrument of Delegation (noting non-clinical assessors must have the non-clinical assessment delegate System role to exercise the Assessor Portal functions).
Clinical assessment delegate	Business and System	A clinical assessment delegate performs functions and powers of the System Governor delegated to their role as detailed in Chapter 7-8 of the Aged Care Assessment Manual, including but not limited to approving an individual for funded aged care services.
Non-clinical assessment delegate	Business and System	A non-clinical assessment delegate performs functions and powers of the System Governor delegated to their role as detailed in Chapter 7-8 of the Aged Care Assessment Manual, including but not limited to approving an individual for funded aged care services under the Commonwealth Home Support Program. Non-clinical assessors and Clinical assessors hold this role under the Instrument of Delegation (noting these assessors must have the non-clinical assessment delegate System role to exercise the Assessor Portal functions).
Workplace trainer	Business	A workplace trainer provides and coordinates the mandatory training required to be undertaken by staff within of an assessment organisation in accordance with the Aged Care Workforce Learning Strategy and Chapter 2 of the Aged Care Assessment Manual.

Role Title	Role type	Role Description
Administration officer	Business	An Administration Officer provides support to the Team Leader and delegates, by performing the day-to-day work of phoning and booking appointments, assigning the booking to assessors, rescheduling and reassigning an assessment should any changes need to occur (assessor on unplanned leave, older person needs to change the appointment) and assigning SPRs. Administration officers may hold the team leader system role to manage and assign, un-assign and reassign referrals or transfer referrals for triage and assessment(s) and assign SPRs to an assessor.
Delegate support officer	Business and System	Delegate Support provide support to the assessment delegate with administrative tasks associated with delegation such as printing and sending letters.



My Aged Care Assessor Portal - Organisational Administrator User Guide

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

Culturally safe assessments are everyone's responsibility. All organisations within the Single Assessment System are accountable for ensuring assessments are culturally safe.

As Aboriginal and Torres Strait Islander assessment organisations are embedded within communities, these organisations are well placed as trusted intermediaries to inform their communities about the Aboriginal and Torres Strait Islander Assessment pathway through communication channels that best suit the community.

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

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

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

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

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

2.6. Training requirements for assessment teams

The My Aged Care Workforce Learning Strategy v1.5 (Workforce Learning Strategy), defines and sets the mandatory, minimum training requirement for the Single Assessment System workforce and the My Aged Care workforce, including timeframes for completion. Training occurs as part of the staff members induction into the assessment organisation. Some roles have mandatory credential requirements. Details of these qualification requirements are provided in Appendix F. The assessment organisation is responsible for validating that each person has the required qualifications for their role before requesting registration for training.

The department and assessment organisations are jointly responsible for training assessment organisation staff. The Workforce Learning Strategy explains the blended approach to mandatory training requirements including on-line training, on-the-job learning and learner appraisal. This approach also acknowledges existing knowledge and skills of the workforce, and that learning is ongoing.

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

2.6.1. Training delivery

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

Aboriginal and Torres Strait Islander Assessment Organisations participating in the pilot are responsible for ensuring their workforce is ready to deliver assessment activities. Flexible training approaches may be applied, as appropriate, to support their establishment and ongoing operation.

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

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

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

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



- My Aged Care Workforce Learning Strategy
- My Aged Care Quality Learning Framework

2.7. The single assessment pathway

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

Upon accepting an assessment referral, assessment organisations are expected to actively engage with the older person as well as their support networks. This may include, but is not limited to, Elder Care Support staff, care finders, aged care providers, GPs, Aboriginal Community Controlled Health Organisations, social workers, and other relevant parties who may have facilitated the older person to access the aged care system. This engagement aims to develop a comprehensive understanding of the needs of the older person.

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

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

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

All assessment organisations may deliver assessments through subcontracting arrangements subject to approval from the department.

2.7.1. Home support assessments

Non-clinical assessors undertake home support assessments of an older person's care needs under the *Aged Care Act 2024,* using the IAT. Home support assessments are appropriate for older people who have entry level care needs.

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

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

Converting to a comprehensive assessment

At the end of the assessment, the IAT Outcome may result in a Support at Home classification level, or the assessor may determine that the older person has intensive and complex care needs. In these circumstances the assessment must be converted to a comprehensive assessment in the IAT before Support at Home or Residential Aged Care can be added to the support plan (see Chapter 5). If this conversion is initiated by a non-clinical assessor, they will need to seek the supervision of a clinical assessor in accordance with their organisation's clinical governance framework and standard operating procedures. The Support Plan will be submitted for approval by a clinical

assessment delegate, and a Notice of Decision will be generated and sent to the older person and any of their registered supporters who are entitled to receive this information.

2.7.2. Comprehensive assessments

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

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

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

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

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

2.8. Other assessment activities

2.8.1. Support plan reviews (SPR)

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

2.8.2. Wellness and reablement

The provision of wellness and reablement approaches are embedded in the aged care assessment. These approaches build on people's strengths and goals to promote greater independence and autonomy in daily living tasks. They avoid 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves without needing on-going service delivery, or with a reduced need for services. Reablement involves supporting participants to maintain or regain skills, improving functional capacity, improving confidence and enhancing capability so an older person can resume everyday activities.

All assessors should adopt wellness and reablement approaches during the assessment and consider whether a recommendation for time-limited reablement under the CHSP is appropriate. Time-limited reablement services tend to be delivered within a 12-week period with the aim to wrap up services when the older person has met their goal or specific outcome. This involves the older person and reablement providers working together to plan how they will address specific barriers to independence and achieve the client's goal.

2.8.3. Linking support

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

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

2.8.4. Assessment delegations

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

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



For further information about delegate roles, their functions and responsibilities refer to Chapter 7: Delegations and approvals under the Act.

2.8.5. Multi-disciplinary approach

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

A multidisciplinary approach to aged care assessment for older Aboriginal and Torres Strait Islander people should go beyond a clinical assessment and must consider the client's social, emotional, and cultural wellbeing. It may involve collaboration with other professionals, social workers, community members, as part of the assessment and guided by the client. This is to ensure the assessment is holistic, culturally safe and responsive to the person's needs. Respect and care for Aboriginal and Torres Strait Islander peoples' ways of working is critical to building reciprocal trust and the client's ageing well outcomes.

This approach should also be applied to other people who have experienced trauma such as people from diverse backgrounds and life experiences. Assessors need to apply trauma-aware, culturally safe and rights-based approaches to assessment, consistent with the Statement of Rights under the *Aged Care Act 2024*, to uphold older people's dignity, autonomy, safety, informed choice and control, and to minimise the risk of re-traumatisation. For further information see Chapter 12.

2.9. Aims and key features of assessment

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

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

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

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

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

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

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

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

2.10. Assessment quality

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

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

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

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

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

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

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

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

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

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

2.11. Integrated Assessment Tool (IAT)

The IAT was developed as part of the aged care reforms undertaken in accordance with the Australian Government's response to recommendations from the Royal Commission into Aged Care Quality and Safety.

The IAT is the tool prescribed by s62-5 of the *Aged Care Rules 2025* for the purposes of s62(1) of the *Aged Care Act 2024*, which assessors must use to undertake assessment, and includes Validated Assessment Tools. The IAT is essential for capturing a comprehensive profile of an older person's needs, ensuring accuracy and consistency in decision-making. The IAT consolidates key information about an older person's needs across a number of domains, providing a holistic view of their health and circumstances. Additionally, embedded validated tools assess abilities and capacity, forming a solid evidence base for determining care needs.

The IAT is divided into 13 sections. Some of the sections contain nested questions to tailor assessments, only diving deeper into areas where needed.

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



IAT Offline Form

IAT User Guide

2.11.1. Validated Assessment Tools

Where appropriate, assessors should consider using culturally appropriate validated tools within the IAT to deliver culturally safe, trauma aware and healing informed assessments. These tools are detailed in Table 12

Table 12. Validated culturally appropriate assessment tools

Validated culturally appropriate tool	Short description
Good Spirit Good Life (GSGL):	The GSGL addresses gaps in health and aged care by providing a culturally-informed approach to measuring, understanding and meeting the quality of life of older First Nations people. The tool measures wellbeing using 12 interconnected factors which are important to the First Nations people, such as family and friends, connection to Country, community, culture, health, respect, their role as an Elder, support services, safety and security, spirituality, future wishes and basic needs being met. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions • Guidance on Good Spirit Good Life is available at: https://www.aboriginalageingwellresearch.com/gsgl-resources (registration required to view) This tool is available in the Integrated Assessment Tool (IAT).
De Morton Mobility Index - modified	The DEMMI-modified measures the mobility of older people across clinical settings and rates what the person is capable of doing (Can Do), rather than what they currently do. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions • The completion of Departmental training on the DEMMI-modified and a quiz on the Department's learning management system – MAClearning - is required before it can be used in a client assessment. • AN-ACC Assessor Manual for guidance on responding to questions in the DEMMI-modified validated tool.

Validated culturally appropriate tool	Short description
Duke Social Support Index – Social Interaction Subscale	The Duke Social Support Index (DSSI) intends to capture essential components of social support related to mental health outcomes and the use of health services in treating older individuals with non-psychiatric medical illnesses. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer this validated tool with a client at an assessment. • Guidance on the DSSI is available at - Duke Social Support Index
Step 1 GP Cog and Step 2 GP Cog	The GP-Cog is a reliable, valid, and efficient instrument to screen for dementia. The GP-Cog score is not influenced by the cultural and linguistic background of a person making it an invaluable screening tool especially in multicultural patient settings. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer this validated tool with a client at an assessment. • Guidance on the GP-Cog is available at - GP-COG
Patient Health Questionnaire-4 (PHQ-4)	The purpose of the PHQ-4 is to allow for ultra-brief and accurate measurement of core symptoms/signs of depression and anxiety by combining the two-item measure (PHQ–2), consisting of core criteria for depression, as well as a two-item measure for anxiety (GAD–2), both of which have independently been shown to be good brief screening tools Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Some guidance on PHQ-4 is available at: Anxiety & Depression (PHQ-4) | The WELL Office – McGill University

Validated culturally appropriate tool	Short description
Geriatric Depression Scale	The Geriatric Depression Scale (GDS) (15 point version) is a depression assessment tool specifically designed for older people. The GDS can be filled out by the client or administered by an interviewer. It comprises 15 questions about how the client has felt over the past week. Questions require yes/no answers. Some items in the GDS may not be appropriate at all times for all cultural groups. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer this validated tool with a client at an assessment.
KICA Cog	A validated cognitive assessment tool for older Indigenous Australians, aged 45 years and older, in remote settings for whom other dementia assessments are not suitable. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer this validated tool with a client at an assessment. • KICA COG (Remote) • Instruction Booklet This tool is available in the Integrated Assessment Tool (IAT).
KICA Cog Urban Regional	KICA was modified for use with Aboriginal people in regional and urban settings. The regional and urban KICA is an instrument to assess dementia in older Aboriginal people in regional and urban settings. **Additional information and training resources:** Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance

Validated culturally appropriate tool	Short description
	on how and when to administer this validated tool with a client at an assessment. • Guidance on the KIKA Cog Urban Regional is available at Indigenous Cognitive Assessment: Regional and Urban KICA | National Ageing Research Institute Limited (nari.net.au) This tool is available in the Integrated Assessment Tool (IAT).
KICA Carer	The KICA-Carer is an informant questionnaire given by the interviewer. It is the informant cognitive subsection of the KICA that was developed and validated in the Kimberley region of WA. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Kimberley Indigenous Cognitive Assessment – KICA-Carer This tool is available in the Integrated Assessment Tool (IAT).
Revised Urinary Incontinence Scale	The Revised Urinary Incontinence Scale (RUIS) is a validated tool to assess the severity and impact of urinary incontinence in adults. The RUIS consists of 10 items that assess the frequency, amount, and impact of urinary incontinence, as well as the patient's level of concern related to incontinence. Each item is scored on a scale from 0 to 3, with higher scores indicating a greater severity and impact of urinary incontinence. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Revised Incontinence and Patient Satisfaction Tools Version 2 – Technical Manual and Instructions • RUIS Brochure – Summary for assessing and monitoring urinary incontinence. • International Continence Society (ICS)- RUIS - study findings

Validated culturally appropriate tool	Short description
	• Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer the RUIS with a client at an assessment.
Revised Faecal Incontinence Scale	The Revised Faecal Incontinence Scale (RFIS), is a validated assessment tool used to assess the severity and impact of fecal incontinence in adults. The RFIS is designed to be simple and effective and can be completed by a trained healthcare professional. Please refer to the below guidance material for information on completing this validated tool and appropriately asking questions. • Revised Incontinence and Patient Satisfaction Tools Version 2 – Technical Manual and Instructions • RUIS Brochure – Summary of assessing and monitoring faecal incontinence. • Please review the MAClearning element Validated Assessment Tools in Practice for further guidance on how and when to administer the RFIS with a client at an assessment.

3. Chapter 3: Referral, registration and screening

What you'll find in this chapter

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

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

3.1. Entry into My Aged Care

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

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

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

Note:

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

3.1.1. Modes of entry into My Aged Care

Phone

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

The My Aged Care Contact Centre receives inbound calls, creates records for older people, progresses the registration and cancellation of supporter and agent relationships,

raises SPR requests, screens for needs and refers older people to assessment organisations and service providers and/or provides information to older people.

The My Aged Care contact centre can help older Aboriginal and Torres Strait Islander people indicate their preference for an Aboriginal and Torres Strait Islander assessment organisation.

Online

Apply for an assessment online

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

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

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

Web referrals (Make a Referral form)

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

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

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

If the GP or health professional recommends a comprehensive assessment and the older person has previously been assessed for a home support assessment, the web referral will be intercepted and follow the SPR pathway rules to the assessment organisation that undertook the most recent assessment, regardless of the recommendation (unless the request qualifies for a direct comprehensive assessment referral, such as for TCP).

GP e-Referral

GPs may also choose to use GP e-Referrals which can be accessed from their practice management system. The form will pre-populate the patient's information with the GP then adding any additional information and attachments as required. It is then submitted

safely and securely to My Aged Care for processing and will follow a similar process to that outlined for the Make a Referral form.

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

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

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

ACSOs can create records for older people, progress registration and cancellation of supporter and agent relationships, screen for needs and refer older people to assessment organisations and service providers and/or provides information to older people.

ACSOs can help older Aboriginal and Torres Strait Islander people indicate their preference for an Aboriginal and Torres Strait Islander assessment organisation.

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

Services Australia website: Aged Care Specialist Officer

3.1.2. My Aged Care Online Account

Create account and registration

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

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

3.2. Alternative entry

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

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

- **Urgent services**: The individual was in urgent need of access to funded aged care services and there was a significant risk of harm to the individual if services were not provided before an approval was given.

- **Lack of availability of culturally safe assessments**: The individual is an Aboriginal and Torres Strait Islander person and at the time the individual sought access to funded aged care services, there was a lack of availability to access a culturally safe assessment.

- **Services commenced through a specialist aged care program and there is a significant delay in assessment**: The individual started to receive care from a specialist aged care program (such as CHSP, MPSP or NATSIFACP) before approval was given, and at the time the individual sought funded aged care services, there was a significant delay in the availability to undertake a needs assessment.

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

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

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

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

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

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

Individuals (often with the support of their provider) have a period of **5 calendar days** after the day on which services commenced to make an application under section 71 of the Act, for example if receiving 'urgent services through the CHSP'.

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

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

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

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

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

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

These referrals are issued by triage delegates and, in some circumstances, My Aged Care Contact Centre staff or ACSOs during screening. Specific **referral codes** are not generated at this stage; direct-to-provider referrals are issued instead. Referral codes for CHSP services are **only** generated after an assessment has been completed and the services have been approved by an assessment delegate.

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

- New individuals who are applying for an aged care needs assessment
- Current CHSP clients who have been reassessed for Support at Home and are waiting for their budget allocation
- Support at Home participants who have a fully allocated budget, or are waiting for a budget allocation, and who face an immediate health and safety risk requiring urgent services.

Screening

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

These services are:

- nursing
- transport
- meal delivery
- personal care
- other support services due to the absence of a carer, such as flexible respite.

When issuing an urgent referral, the My Aged Care Contact Centre or ACSO will place a high priority on the referral to an assessment organisation. For an existing client who has previously been assessed, the contact centre or ACSO will issue a SPR request (unless the older person meets the requirements for a direct assessment referral).

Triage

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

Triage delegates should:

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

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

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

Assessment

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

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

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

For CHSP clients - where an assessor determines the individual requires ongoing CHSP services after a period of urgent services, they **must add new CHSP referrals for any (new) services**. For more information see section 9.4.5 CHSP referrals.

3.2.2. Residential care or residential respite care in urgent circumstances

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

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

3.3. Screening

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

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

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

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

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

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

3.3.1. Outcomes of screening

On completion of the screening:

- Assign referral priority to indicate the timing of the assessment and the urgency in which services are delivered to an older person, which is based on an older person's level of function, the level of risk in relation to the care situation and any other relevant concerns.
- Send the referral to an appropriate assessment organisation with the older person's consent.
- For urgent referrals for the End-of-Life Pathway, ensure the referral is marked as 'End-of-Life.'
- Send urgent service referrals direct-to-CHSP provider with the older person's consent and **send an assessment referral at the same time**. If urgent services are approved, Assessment delegates can backdate approvals for the urgent services after an assessment, see Section 3.2.

Note: Where a referral is issued to the organisation in error, the My Aged Care Service Provider and Assessor Helpline can recall the referral (see Chapter 4 Referral for assessment).

3.4. Support networks for an older person

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

3.4.1. Registered supporters

Supported decision-making in aged care legislation

Everyone has the right to make decisions about their life, including the support and services they receive from aged care.

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

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

Supported decision-making in assessments

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

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

This might look like:

- Asking the older person to make decisions about their aged care services and needs (rather than deferring to their family, registered supporters or their active, appointed decision-maker),
- Checking whether an older person has a registered supporter, and whether the older person wants that person to provide support. Remember that having a registered supporter does not mean that the older person needs to include them in discussions and their decision-making processes. It is always up to the older person. A registered supporter can only act in line with the older person's known will and preferences, and
- Considering how supported decision-making principles can be embedded into an assessment process. This could be:
    - more time for the older person to explore options and only asking them to make one decision at a time,
    - presenting the older person with options in ways the older person prefers, such as visually, and
    - encouraging and supporting the older person to make decisions at a time and place most comfortable for the older person.

Role of registered supporters

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

Under the Act, older people can still choose who can support them to make decisions, if they want or need support. These people can be – but don't always have to be – registered supporters. A registered supporter may be a trusted family member or friend or anyone else of an older person's choosing, who can help them to request, access and understand information and communicate their wishes.

There are benefits to registering a supporter. Registered supporters can:

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

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

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

An older person does not have to register a supporter. Some older people might feel they are already supported by their carers and other significant people in their lives, without

needing any of them to become a registered supporter. These people can continue to play an important role in supporting an older person, regardless of whether they are a registered supporter. This means, with the older person's consent, someone who is not a registered supporter may continue supporting an older person during their assessment as a third party. The older person may provide their consent for the third party to communicate their decisions and wishes, but this consent is not enduring and is limited to the interaction at the time.

Assessors must ensure that the older person has provided their consent each time a third party is communicating the decisions of, or information for, the older person.

Guidance for assessors when engaging with someone seeking to make a decision on behalf of an older person is provided in the sections on appointed decision makers.

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

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

Active, appointed decision makers

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

Decision-making arrangements differ across Commonwealth, state and territory jurisdictions. As such, the authority a person may have to make decisions for an older person may be subject to different requirements and conditions. In some circumstances, a person's authority to make decisions for an older person is not enlivened until the older person is found to have lost, or be experiencing a loss, in their decision-making ability, for some or all decisions. Before actioning a request or decision made by a person other than an older person, assessors need to consider the person's decision-making authority for an older person, including when it becomes active, on a case-by-case basis. This may involve sighting medical evidence about the older person.

If a registered supporter who is also an appointed decision maker is supporting the older person to make a decision that falls outside the scope of their Commonwealth, state or territory arrangement, they must not make the decision on the older person's behalf. For example, where an active, appointed decision maker has financial decision-making authority only, they cannot make personal decisions for the older person - they should instead support the older person to make that decision. If the older person wants support, the registered supporter should adopt principles of supported decision-making in line with the duties of a registered supporter.

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

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

Where there is no appointed decision maker

My Aged Care understands that there may be times where an older person is no longer able to make decisions and has no one in place with legal authority to make decisions for them.

While My Aged Care cannot give anyone decision-making powers to act on an older person's behalf, there are steps that those supporting them can take to enable an older person to receive the care and support they need.

One option is to submit an application for a guardianship and/or administration order with a state or territory court, board, panel or tribunal. They can conduct a hearing and decide if a person requires a legal decision maker. They can also decide who this person will be and what decisions they may make. Some state and territory processes also include emergency options to appoint a decision maker quickly if necessary.

Further information about appointed decision makers can be found on the My Aged Care website at appointed decision makers.

Consent and registered supporter types

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

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

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

- **Supporter** – a person who the older person consented to registering as a supporter **and** to be automatically given information and documents that may or must be given to the older person under the Act.
- **Supporter lite** – a person who the older person consented to registering as a supporter but **not** to be automatically given information and documents that may or must be given to the older person under the Act.
- **Supporter guardian** – a person who is registered by the System Governor as a supporter and who, in becoming registered, relied on their authority as an active, appointed decision-maker for the older person under a Commonwealth, state or territory arrangement.

The following table summarises these types and the consent requirements:

Table 13. Supporter relationships and consent requirements

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

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

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

Duties

All registered supporters have duties under the Act that they must comply with. Registered supporters must act honestly, diligently, and in good faith when undertaking these duties. These duties are intended to promote an older person’s safety, rights and will and preferences.

The duties include that registered supporters must:

- Act in a way that promotes the will, preferences, and personal, cultural, and social wellbeing of the older person they are supporting.
- Act honestly, diligently and in good faith.
- Support the older person only to the extent necessary for the older person to do the thing themselves.
- Apply their best endeavours to maintain the ability of the older person to make their own decisions.
- Declare, and avoid or manage, conflicts of interest.

These duties apply when a person is acting as a registered supporter, including when they are requesting, accessing, receiving or communicating information for the older person to support the older person to make or communicate an aged care decision.

Registered supporter Conflicts of interest

Registered supporters have a duty to avoid or manage conflicts of interest they have in their role as a registered supporter, and to inform the System Governor of conflicts as they arise.

A conflict of interest arises if a registered supporter's personal or professional interests or obligations interfere with, could compromise, or may influence the supporter's ability to carry out their role under the Act. This could include a conflict between the older person's interests and the registered supporter's interests. A conflict of interest can be real, potential or perceived. A conflict of interest that cannot be avoided or managed can call into question the registered supporter's ability to be impartial, selfless and perform their role under the Act.



Conflicts of interest policy | Australian Government Department of Health, Disability and Ageing

Acting in line with the older person's known will and preferences

A registered supporter must act in line with an older person's known will and preferences. This includes when a registered supporter is:

- requesting, accessing, or receiving information or documents, and
- communicating information, including the will, preferences and decisions of the older person.

The role of a registered supporter is not to make decisions on behalf of an older person, even if that decision is based on the older person's known or likely will and preferences.

An older person's known will and preferences are what the older person currently wants, now or in the future. The only way to know an older person's will and preferences is to communicate with them. This means that a registered supporter needs to communicate with the older person about how they want to be supported with their decision-making and what their current will and preferences are.

If a registered supporter seeks to make an aged care decision on behalf of an older person, they can only do so as an active, appointed decision maker recognised under the

Act (if that decision is within the scope of their active, legal authority), not as a registered supporter. Active, appointed decision makers must act in accordance with the conditions and requirements under their relevant Commonwealth, state or territory arrangement. These arrangements will have specific requirements relating to how and when decision-making authority can be exercised.

Suspension and cancellation of a registered supporter

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

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

While assessors cannot suspend the registration of a supporter, assessors do have a role in raising or handling complaints. If an assessor believes that a registered supporter is not acting in compliance with their duties under the Act or is otherwise concerned about the basis for which a person was registered by the System Governor, they are encouraged to raise this with the System Governor team responsible for registered supporters. This can be done using the online form for making a submission to the System Governor responsible for supporters.

No requirement to register a supporter

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

Transitioning to the registered supporter role

Most representative relationships in My Aged Care went through changes to come under the Act. If an older person had a regular or authorised representative active in My Aged Care on 31 October 2025, they became a registered supporter under the Act on 1 November 2025. This ensured that older people seeking or receiving aged care services continued to have decision-making support available to them.

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

Representative arrangements made under the Quality of Care Principles 2014 no longer exist under the Act. Further, these arrangements did not automatically transition to the Act. These representatives were encouraged to become registered supporters under the Act.

- Key information and pathways to request to register a supporter: www.myagedcare.gov.au/registering-supporter
- Information on appointed decision makers: www.myagedcare.gov.au/registering-supporter/appointed-decision-makers
- Registered supporter policy library: https://www.health.gov.au/resources/collections/registered-supporter-resources
- Guide to using the Assessor Portal: My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships
- Information about transitional arrangements in place for My Aged Care representatives before 1 November 2025: Transition arrangements for the new registered supporter role | Australian Government Department of Health, Disability and Ageing
- My Aged Care – Registration of a Supporter form
- My Aged Care – translated resources

3.4.2. Organisation Agents

An Organisation Agent is defined as an organisation that is approved and funded by the Department of Health, Disability and Ageing to provide assistance to clients in navigating and accessing the aged care system. Currently there are three approved Organisation Agents: OPAN advocacy organisations, care finders and Elder Care Support organisations.

Organisation Agent relationships can be created by agents through the My Aged Care Service and Support portal or by the My Aged Care contact centre, ACSOs or assessors. An older person cannot create their own agent relationships.

Getting support to navigate aged care | My Aged Care

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

3.5. Exceptional Circumstances – approving a service without an assessment

In some circumstances, under section 65(4) of the *Aged Care Act 2024* a client may be approved to access aged care services without undergoing an aged care needs assessment owing to exceptional circumstances. This will typically occur where a person is accessing funded aged care services through the alternative entry pathway but pass away prior to receiving an assessment.

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

Client is receiving services but is refusing an assessment

If the Triage delegate or assessor consider there are valid reasons for the person refusing to have an assessment, assessment organisations are to contact the department in the first instance at MyAgedCareAssessment@health.gov.au for assistance. In some cases, the department may exercise delegation to approve services under the exceptional circumstances provision.

If assessment is cancelled or exceptional circumstances do not apply

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

3.6. Emergency Residential Care - Application for Care

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

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

Residential care (ongoing or short-term)

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

In completing the form**:**

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

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

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

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

3.6.1. Intake and assessment process

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

- Ensure the form signed by the older person, or their active, appointed decision maker, and confirm the *emergency case* section is completed correctly by the registered provider.
- Confirm the date the form was received. If it was submitted after 5 calendar days from the care start date, assessment can only proceed if the provider has been granted an extension by the department as System Governor, following an application for extension. Providers can request an extension by emailing **MyAgedCare.Assessment@health.gov.au**.
- Register and self-refer the older person in the My Aged Care assessor portal (if required and self-referral criteria are met).
- Assign assessment priority. Although the older person is already in care, the Triage Delegate must consider the urgency of their circumstances. If the older person's condition is rapidly deteriorating, the assessment should be scheduled as soon as possible.
- Upload the verified form to the older person's record.
- Schedule a comprehensive assessment with an assessor. Where possible, this should be face-to-face and collect information to:
    - Determine the older person's required level of care; and
    - Confirm that urgent circumstances existed at entry and that prior approval was not practicable.
    - Note: for respite care assessments, the DEMMI modified tool must be undertaken face to face by clinical assessors only.

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

4. Chapter 4: Referral for assessment

What you'll find in this chapter

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

The following topics are covered in this chapter:

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

4.1. Managing referrals

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

4.2. Referral priority categories

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

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

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

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

4.2.1. Home support assessment priority categories

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

Table 14. Home support assessment priority categories

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

4.2.2. Comprehensive assessment priority categories- community setting

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

Table 15. Comprehensive assessment priority categories – community setting

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

4.2.3. Hospital assessment priority categories

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

Table 16. Hospital assessment priority categories

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

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

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

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

4.3. Actioning referrals

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

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

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

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

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

- This should be recorded when registering a client in the My Aged Care system
- It may also be recorded by an assessor during an assessment.
- Once recorded, the preference will be displayed in the client details as well as on the client's card.
- If one is available, Aboriginal and Torres Strait Islander assessment organisations will be represented with a prefix "FNAO-" and appear at the top of the list of available assessment organisations. If none is available in the region, then no organisation on the list will have the prefix.
- Team Leaders will receive system notification if the client has indicated a preference but is being transferred to another assessment organisation that is not an Aboriginal and Torres Strait Islander assessment organisation.
- Sometimes, the older person will want to know the name of the available organisation(s) before being referred to them.

An older Aboriginal and Torres Strait Islander person may change or withdraw their preference at any time. Assessors are expected to respect and support the person's preferences.

Note:

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

In regions where these services are still being established, an older Aboriginal and Torres Strait Islander person will not be able to be referred to an Aboriginal and Torres Strait Islander assessment organisation. Information about an older person's preference will be collected and used to understand demand for these services. Once Aboriginal and Torres Strait Islander assessment organisation become available in their region, this preference information will guide referrals for an assessment or support plan review.

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

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

If an Aboriginal and Torres Strait Islander client is already scheduled for an assessment with a mainstream assessment organisation and an Aboriginal and Torres Strait Islander assessment organisation becomes available in their area; the client should be advised of this option. They should be informed that choosing to be transferred to an Aboriginal and Torres Strait Islander assessment organisation may result in a longer wait time for an assessment. Clients should also be informed that there will be future opportunities to transfer to the new organisation if their needs change.

When discussing this option, the client's health condition and care needs must be taken into consideration to ensure that any potential delay in assessment would not adversely impact their wellbeing. Unless the client chooses to be transferred, the assessment should continue as originally planned.

Any preferences for Aboriginal and Torres Strait Islander assessment organisations should be identified during the assessor's pre-assessment planning. This allows time to arrange a transfer prior to the scheduled assessment, if needed. Making a referral change at the point of assessment may significantly lengthen the client's wait time, which is not the desirable outcome.

It is recommended that assessors discuss this with the client prior to the assessment to ensure that they have choice, control and the ability to make informed decisions regarding their care. If the client's preference is to be assessed by an Aboriginal and Torres Strait Islander assessment organisation, the assessor can manage the referral in accordance with the processes detailed in this Chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

During the scale up of services, it is important that assessors and assessment organisations stay up to date on which Aboriginal and Torres Strait Islander assessment organisations are available and their locations. Staying up to date ensures that clients are offered appropriate options and supports timely, culturally safe referrals. To support this awareness:

- The department will provide updates through communications such as email notifications, and messages within the relevant platforms as services roll out.
- Aboriginal and Torres Strait assessment organisation outlets will be prefixed with "FNAO-" and appear at the top of the list of available organisations.
- Aboriginal and Torres Strait Islander assessment organisations are listed on the interactive map of available services.
- The Department's website will be updated regularly.


Guidance material for Single Assessment System assessors – Aboriginal and Torres Strait Islander aged care assessment organisations

4.3.4. Unlikely to be eligible for an assessment flag

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

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

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

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

4.3.5. End-of-Life referrals

Assessors must undertake High Priority Assessments for new End-of-Life clients. The Assessor Portal will include system capability for team leaders and triage delegates to flag clients as an 'End-of-life client' through the High Priority assessment process. The aged care assessment referral will be flagged as an 'End-of-Life referral' and will be given a high priority. Assessors will be able to identify referrals for the End-of-Life Pathway through a visual indicator that marks the referral as End-of-Life, and through filtering for the End-of-Life Pathway. However, **it is important to note that current system functionality does not allow team leaders to identify Support Plan Reviews for the End-of-Life Pathway through the same mechanisms** (team leaders will be able to filter by urgency, but they will be unable to see the visual indicator or filter specifically for End-

of-Life). Instead, upon receiving urgent requests for Support Plan Reviews, it is important that team leaders click the double arrow icon to expand the referral card, verify whether it relates to the End-of-Life Pathway and prioritise it accordingly. This must be done for all incoming referrals for Support Plan Reviews to ensure older people seeking access to the End-of-Life Pathway are prioritised. A temporary workaround is available for via Qilk, refer to the Identification of End-of-Life Clients Via Qlik – Guidance on the Assessment Hub for more detailed guidance.

For CHSP clients who are seeking the End-of-Life Pathway via a SPR, if the assessor or team leader is satisfied the referral is an End-of-Life request, they can select the "recommend new assessment" button under the "before you start the support plan review" tab to proceed directly to a comprehensive assessment.

The End-of-Life Pathway Form does not need to be attached to the client's record for the assessment to proceed. If an End-of-Life Pathway Form has not been submitted, the team leader or triage delegate should advise the older person of the steps required. In cases where an aged care assessment or SPR will be undertaken via telehealth, assessors must assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options is included in section 6.3.1.

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

Table 17. End-of-Life Form verification options

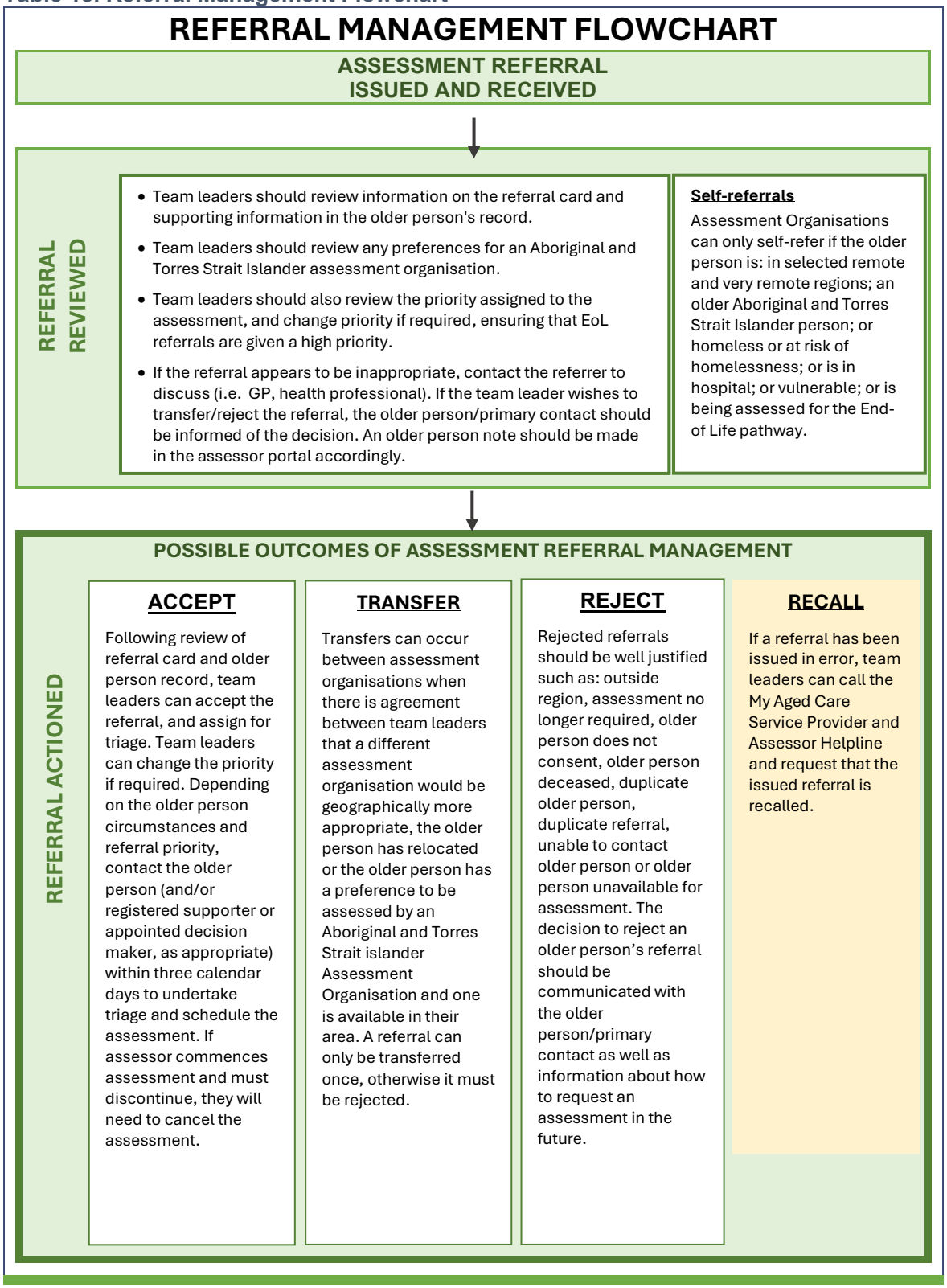
Option	When to use
Document Reviewed - valid	The correct, complete document has been uploaded.
Document Reviewed – pending	The documentation is either incomplete or not provided.
Document Reviewed – invalid	The End-of-Life pathway is no longer needed or the documentation is invalid.

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



My Aged Care – Assessor Portal User Guide 3 – Managing referrals for assessment and support plan reviews | Australian Government Department of Health, Disability and Ageing

Table 18. Referral Management Flowchart



4.3.6. Accept a referral

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

A Team Leader must:

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

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

4.3.7. Transferring referrals

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

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

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

4.3.8. Rejecting a referral

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

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

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

Table 19. Referral rejection - List of values

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

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

Note:

The department monitors the rejected referral rates and rejection reasons, including when the 'other' rejection reason is used.

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

Assessors must make a minimum of **three** attempts to contact the older person and/or their registered supporter or primary contact via **telephone**.

- These attempts must have been made over the KPI timeframe set for the older person based on the type and priority of the referral (i.e. three phone attempts must be made to contact a high priority home support referral over a 10-day period, a medium priority home support referral must be undertaken over 14 days etc.)
- Any number of other forms of contact e.g. text messages, email, can be used, in conjunction with the minimum of three phone attempts. All contact attempts must be documented. It is suggested that where possible, a text message precedes the phone call to alert the client of an incoming call from the AO, especially where the call will be coming from a private number.
- For clients who have special needs or maybe high risk, e.g. identified cognitive and/or hearing impairment, no informal supports, it is expected that a **minimum of five attempts** must be made to contact the older person and/or their registered supporter or primary contact. These attempts must include a minimum of 3 phone calls, one text message and one email, all of which are to be undertaken within the KPI timeframe for the type and priority of referral. All contact attempts must be documented.
- After the required number of contact attempts has been made, a letter must be provided advising the older person and their registered supporter advising how to reactivate their assessment referral request, or informing the older person and their registered supporter (and appointed decision maker, if they have one) if they are rejecting, transferring or cancelling their referral (including an explanation of the reason/s and date and mode of attempted contacts where applicable). This letter must be uploaded to the client record.

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

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

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

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

Note:

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

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

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

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

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

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

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

4.3.9. Recall a referral

Where a referral is issued to the organisation inappropriately and is not at the status of 'rejected' or 'transferred,' the team leader may request to have the referral recalled by contacting the My Aged Care Service Provider and Assessor Helpline on 1800 836 799. Note, the team leader of the outlet will receive a system notification if a referral has been recalled.

The My Aged Care Service Provider and Assessor helpline can recall referrals that were:

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

4.4. Self-referrals

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

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

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

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

When creating the self-referral, assessors are encouraged:

- to upload any additional documentation relevant to the older person's situation (for example, a hospital discharge notice),
- Provide any reasoning relating to the person's vulnerability under the 'Notes' tab in the assessor portal. With the older person's consent, sensitive information should be recorded in sensitive notes and attachments.

4.4.1. Triage and self-referral

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

A triage delegate must actively supervise triage conducted by an assessor, via phone or video conferencing. The decision whether someone is eligible to undergo an assessment, remains with the triage delegate and should not be made in their absence. If a delegate is not available to supervise triage the assessment should be paused until such time a delegate becomes available. Assessors conducting triage during a self-referred assessment must nominate the supervising Triage Delegate. Triage will be unable to be completed unless a supervising delegate has been nominated.

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

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

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

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

When self-referring an individual who is likely ineligible in an in-hospital setting, assessors should refer the individual to an assessment organisation, not to themselves.

This approach ensures the referral is appropriately actioned first by a Team Leader and then allocated to a Triage Delegate, for a determination to be made. If an individual is determined to be eligible, the referral will then be allocated to an assessor to complete an assessment.

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

4.4.3. Prevention of duplicate records

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

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

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

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

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

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

4.4.4. Verifying the individual's legal name

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

Legal name vs preferred name

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

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

Note:

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

This practice may also be relevant in other cultures. If appropriate and culturally safe to do so, an assessor should explore all names an older person may have used during the period they were eligible for aged care services. This helps ensure accurate records and supports respectful engagement.

Additional information in name field

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

Special characters

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

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

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

4.5. Support plan reviews and reassessments

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

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

Note: in this manual, the term 'reassessment' is used to describe an assessment that occurs after an older person has already been assessed at least once. From 1 November, SPRs will be used as a mechanism to adjust an older person's aged

care services without needing to undertake a full reassessment. A reassessment will be conducted when there are *significant* changes to a client's needs or circumstances.

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

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

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

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

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

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

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

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



Further information on SPRs and reassessments see Chapter 10: Support plan reviews and reassessments.

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

Where an initial RCP place has been withdrawn due to the person not entering care within the required take up period (56 days, with a possible 28-day extension), a second unit must not be approved via an SPR. In these circumstances, an SPR should not be used to

attempt to approve a second unit RCP but may be used to assess and approve alternative supports (including the need for a reassessment), based on the person's needs.

4.5.1. SPR and reassessment requests

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

A SPR may be requested by:

- the older person/registered supporter (through the My Aged Care Contact Centre or ACSO)
- a service provider (through the My Aged Care Service and Support portal)
- a GP, hospital, or community health professional through the My Aged Care Service Provider and Assessor Helpline or a My Aged Care web referral.
- If a reablement or linking support period is open, the team leader will ask the assessor to finalise the support period so the SPR request can be issued
- the assessor may initiate a SPR without requiring a request or scheduled SPR.

> Note:
>
> A SPR may be requested when an older person is undergoing reablement and/or linking support.
>
> If the older person is undergoing reablement or linking support, the team leader will not be able to assign the SPR until the support period is marked as completed.
>
> To allow continuity of the support period, the assessor can re-add the support period during the SPR.

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

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

4.5.2. Managing an SPR request

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

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

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

- End-of-Life SPRs, completing them as soon as possible. These will be marked 'urgent' in the system.
- Referrals where referral information indicates a significant event has occurred or the older person has a rapidly deteriorating condition, all of which will likely result in a reassessment. This will help ensure prompt review by a Triage Delegate, who may recommend CHSP services for the individual.
- Requests for **a second unit of restorative care** where the older person is in service and there is a need for continuity of services

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

Transfer the request

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

> Note:
>
> Extra care will need to be taken by team leaders during the staged rollout of Aboriginal and Torres Strait Islander assessment organisations.
>
> There may be instances where a client has had previous interactions with a single assessment system organisation yet has a preference for an Aboriginal and Torres Strait Islander assessment organisation when one becomes available.
>
> In this instance, it is recommended that the client be transferred to an Aboriginal and Torres Strait Islander organisation as per the current warm transfer process.

Recommend a reassessment

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

Cancel the request

Actions if considering cancelling the SPR:

- If there is insufficient information on the SPR request, however clarification is required on certain aspects, the assessor should contact the older person or service provider where possible to clarify the request, prior to progressing a decision to cancel the SPR. This will manage the risk to older people to ensure the older person is not disadvantaged where they require changes to their aged care support.
- The review request may be cancelled by an assessor and a SPR not undertaken if it is inappropriate or if insufficient information is provided to warrant the SPR, or the assessor (after a number of attempts) has not been able to contact the older person's primary contact (who may be the older person, registered supporter, appointed decision maker or agent organisation).
- As a minimum requirement, where the assessor cancels the SPR, they must include the cancellation reason and provide clear explanation justifying the cancellation in the cancellation details field.
- Indicating a clear cancellation reason allows the person making the request to, if necessary, amend and resubmit the request or follow up with the assessor as necessary.
- Where, through the course of the SPR conversation, the older person and/or their supporter considers no changes are required, they may agree that the SPR can be cancelled and withdraw their application. A notice of decision advising on this outcome is not required as the applicant's application is taken to be withdrawn.

Note:

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

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

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

4.6. Deceased older people

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

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

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

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



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

5. Chapter 5: Assessment activities

What you'll find in this chapter

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

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

5.1. Obtaining consent for triage and assessment

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

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

- Triage Delegates or assessors must use the applicable consent script online via the Assessor Portal (or in the app in the case of self-referrals).

- The Triage Delegate or assessor should read out the consent script/s to ensure the older person understands and is informed of the purpose for collecting the information and how it will be used and stored, and who the personal or sensitive information will be collected from (such as contacting a person's GP, other health professionals, disability service coordinator or service provider, family members or carers). If the older person prefers, the older person can read the consent script/s themselves on a printed form.

- For offline assessments, the assessor must use a hard copy version of the My Aged Care Assessment Consent Form. This form includes the consent scripts and fields

to record the consent for assessment and service referrals. It is located via the *Reports and Documents* tile within the My Aged Care assessor portal.

- While the My Aged Care Assessment Consent Form and scripts should be used to obtain consent from older Aboriginal and Torres Strait Islander or culturally and linguistically diverse clients assessors should take care to adapt the consent script, or access interpreters as needed, to ensure that it can be clearly understood.

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

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

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

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

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

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

- Under the Act, assessors must presume that an older person has the ability to make decisions for themselves. This is known as the presumption of capacity. To give an older person the best opportunity to provide consent, assessors may consider the

time of day or location of assessment, whether the assessment should occur on a different day or using different communication methods.

- If an assessor becomes aware of matters that suggest the older person has questioned decision-making ability and consequently may not have legal capacity to provide informed consent to the assessment, the assessor may then seek consent from the older person's active, appointed decision maker (if they have one). In this circumstance, if the assessor cannot identify an active, appointed decision maker who has legal authority to consent to the assessment on behalf of the older person, the assessor may consider that the aged care assessment cannot be undertaken. Further information about the concept of capacity, including when an older person is considered to have questioned decision-making ability, is available in the *Capacity in the registered supporter context* policy document.

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

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

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

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

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

- If using online consent, the triage delegate or assessor must use the My Aged Care portal prompts to indicate that consent to triage/assessment was provided. If the older person does not wish to give consent, the triage delegate or assessor will be required to select a reason for not providing consent.

- If using the Consent Form, the assessor must record the informed consent in the My Aged Care Assessment Consent Form and upload it in the older person's record

through the ‘Attachments’ function. The assessor can then use the ‘Notes’ section in the older person’s record to:

  - indicate the signed form has been uploaded and consent given
  - record any detail the circumstances regarding any disclosure of an older person’s personal information, and
  - record any instructions relating to the assessor’s conversation on informed consent with the older person (and/or active appointed decision maker) and where relevant, any registered supporters.

- If a carer is identified for the first time during the assessment under the ‘Carer profile’ section of the IAT, the assessor must confirm with the older person that the older person has the carer’s consent to provide the carer’s telephone number and related personal information.
- Older people must be made aware that once consent for assessment is gained for the use and disclosure of personal information as authorised by the *Privacy Act 1988* (Cth) (Privacy Act), these records need to be retained in accordance with the *Archives Act 1983*.
- When seeking consent to make the older person’s Support Plan available in their My Health Record (MHR), the assessor should ensure the older person understands that their GP, along with other authorised health professionals, will also be able to view their Support Plan on MHR. The assessor can make a note that the older person does not have to give their consent. They can also withdraw their consent at any time by contacting My Aged Care and requesting removal of their Support Plan from MHR.

Note:

1. If consent cannot be given by the older person or their active, appointed decision maker recognised under the Act (either registered as a supporter or not), the triage or assessment cannot proceed, and the referral is rejected. Further information on registered supporters and active, appointed decision makers is available earlier in this manual.

2. Under changes to the Aged Care Rules from 29 June 2026, assessors can approve Disability Support for Older Australians (DSOA) clients for CHSP only (even if the IAT Outcome is a Support at Home classification). Should a DSOA client still wish to proceed with a Support at Home classification, the assessor should ensure the DSOA client is informed of the considerations relating to their DSOA funding and supports when they consent to proceed with the aged care assessment. DSOA clients must confirm they understand that if they receive aged care services under Support at Home, their DSOA funding is capped, or they may be required to exit the existing DSOA Program (see Chapter 6: Aged care programs).



Privacy notice for Aged Care Needs Assessment: Privacy notice and consent web page

Federal Register of Legislation website:

- Aged Care Act 2024 - Federal Register of Legislation
- The Privacy Act 1988

Healthdirect website: Healthdirect Privacy policy

My Aged Care website:

- Privacy Policy | My Aged Care
- Registering a supporter | My Aged Care

5.2. Triaging assessments

Triage is performed after the acceptance of a referral and prior to conducting an aged care assessment. Triage is conducted for every accepted referral, generally over the telephone and should occur within three calendar days of accepting a referral. Triage helps ensure that older people with low needs are not over-assessed and that those with complex needs have access to a comprehensive assessment. Triage also aims to validate the outcomes produced at screening, including the priority allocated to the assessment and whether urgent services are required. For participants seeking access to the End-of-Life Pathway who have submitted their End-of-Life Pathway Form at this stage, triage may also involve verifying this documentation. In addition, the triage process includes scheduling the assessment, work health and safety screening, arrangements for communication needs and confirming support people ahead of the assessment.

Depending on the older person's circumstances and referral priority, triage delegates should undertake triage with the person and/or the nominated contact within three calendar days of accepting the referral. Older people will require faster response times based on level of risk and need.

Please note for Aboriginal and Torres Strait Islander assessment organisations-in alignment with targets under Outcome Two – Culturally safe, accurate and prioritised assessment under the Aboriginal and Torres Strait Islander Aged Care framework, the client or their representatives should be contacted and an eligibility determined through triage, within 10 days of a referral being accepted by the Aboriginal and Torres Strait Islander assessment organisation. This timeframe acknowledges the importance of culturally safe engagement, including the need for multiple contacts and additional time that may be needed to establish trust and rapport with the client. However, the timeframe will be dependent on the client circumstances and referral priority. The timeframe should not compromise on older people being able to access timely aged care services. To avoid disadvantaging the client, assessment organisations should still aim to complete the triage process within 3 days to enable the older person to receive a timely assessment.

If an Elder Care Support worker has been facilitating an older person's access to the aged care system, the assessment organisation should, with consent from the client, involve the Elder Care Support worker in the triage process.

Where an assessment is self-referred, and the assessor is with the client, the assessor may be able to conduct triage with the client at the same time as the assessment. If the assessor is not a Triage Delegate, the Triage must be completed with oversight from a Triage Delegate. Note that, in the instance of self-referral, triage constitutes one of the 'approved forms' under section 56 of the Act.

5.2.1. Delegation to the Triage Delegate

Triage delegates have powers and functions afforded to the System Governor under the *Aged Care Act 2024* (the Act) delegated to them. Section 58 of the Act relates to eligibility for an aged care needs assessment.

Within an assessment organisation, the person holding a triage delegate role must meet certain qualifications (detailed in Appendix F) and training requirements (detailed in the Aged Care Learning Strategy).

The role of the triage delegate is to determine whether an older person is eligible for a needs assessment for funded aged care services. Prior to 1 November 2025, an older person's eligibility for assessment was determined by the My Aged Care contact centre or ACSO after a person was screened. Under the Act it is determined by the triage delegate.

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

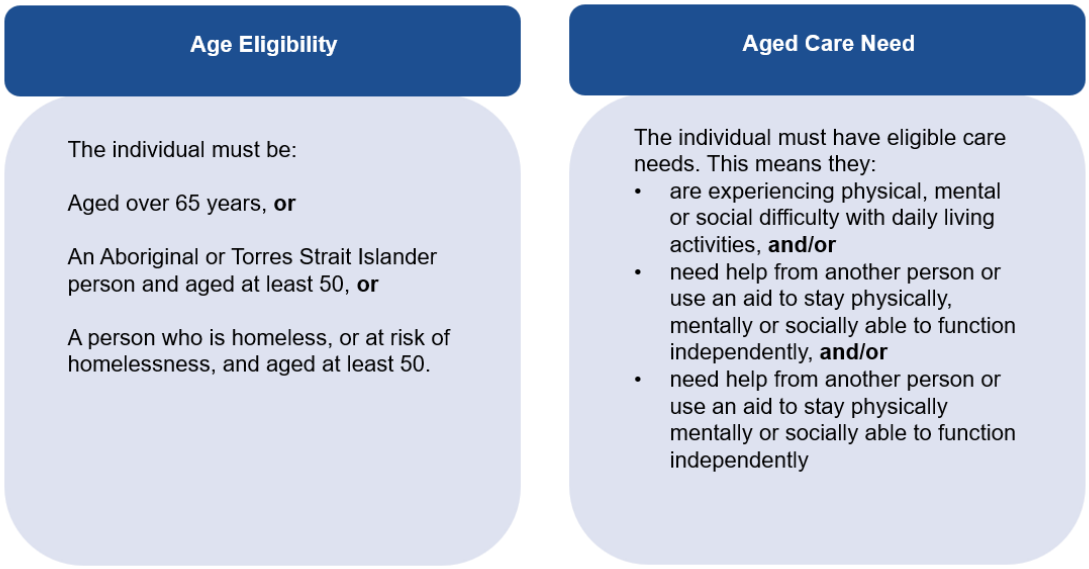


Figure 2 - Eligibility requirements

In doing this the triage delegate must check all information available on the older person's My Aged Care record to confirm:

- the older person's date of birth, by checking with the older person, their registered supporter and/or active, appointed decision maker
- that the older person has declared they have care needs, noting this can be made by the older person through the registration and screening process or through a written statement from a person applying on the older person's behalf, or through written medical records (see section 58-5 of the *Aged Care Rules 2025*)
- for older people who have already been assessed at least once, the older person has had a significant change in circumstances and a reassessment is required. Significant changes are provided for in the *Aged Care Rules 2025* and include:
    - a carer for the older person has permanently ceased to provide some or all care to the older person;

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

The triage delegate should also undertake the triage questions within the Assessor Portal to determine the type of assessment (home support or comprehensive) for the individual.

If a person has gone through the screening process and been advised they are likely to be ineligible for the needs assessment, a flag will appear in the My Aged Care Assessor Portal. Triage delegates should use all available information from screening, on the older person's My Aged Care Profile and provided during triage to reach their own decision regarding an individual's eligibility. Triage Delegates are ultimately responsible for the decision about an older person's eligibility for a needs assessment.

Where the client is clearly ineligible, e.g., due to age, the Triage Delegate can decide that the client is not eligible without completing the triage questions within the Assessor Portal.

In addition to determining the eligibility for an older person to undergo a needs assessment, Triage Delegates should also undertake the triage questions within the Assessor Portal and determine the assessment type and assign to an appropriate assessor.

Under the Instrument of Delegation, Triage Delegates will also be delegated the power to decide under section 64 of the *Aged Care Act 2024* that an older person has undergone a significant change of circumstances or other change in their circumstances and requires a reassessment of their needs. The information required by Triage Delegates to confirm a reassessment will be gathered by assessors during a support plan review.

Triage Delegates should pay special attention to any clients that are marked as unlikely to be eligible due to their age and check if their application for care was already in-progress before 1 November 2025. See section 1.5.11 Younger people in Chapter 1.

5.2.2. Eligibility considerations for older Aboriginal and Torres Strait Islander people

The assessment process for Aboriginal and Torres Strait Islander people between 50-64 years of age is the same process for assessing people aged 65 years and older. Under the *Aged Care Act 2024*, triage delegates will be required to inform people who are under 65 and seeking aged care services of alternative services that may meet their needs, prior to determining their eligibility (see section below). The person seeking assessment is not required to take up these services.

A person does not need to provide proof that they are Aboriginal and Torres Strait Islander. Self-identification, or identification by a person or organisation they trust is sufficient for aged care purposes.

Important: older Aboriginal and Torres Strait Islander people may be members of the Stolen Generations and/or be impacted by displacement and social disruption and

therefore may be traumatised by having to demonstrate their Indigeneity. If a person identifies as Aboriginal and Torres Strait Islander it is important for this to be documented during the assessment for eligibility, service and data collection purposes.

5.2.3. Eligibility considerations for people who are homeless or who are at risk of homelessness

The assessment process for people who are homeless or at risk of homelessness between 50-64 years of age is the same process for assessing people aged 65 years and older. Under the Act, triage delegates will be required to inform people who are under 65 and seeking aged care services of alternative services that may meet their needs, prior to determining their eligibility (see section below). The person seeking assessment is not required to take up these services.

The following definitions apply for this cohort and must be used when determining someone's eligibility for an aged care needs assessment who is aged between 50 and 64 years.

Homeless definition

'Homeless' in the context of aged care and for the purpose of receiving Australian Government funded aged care services refers to an individual who:

a) is aged 50 or older, and
b) has prematurely aged and requires services for their aged care needs, and
c) has the following living arrangements:
    - Lacks any adequate roof over their head, or
    - Has no security of tenure, or moves between various forms of temporary or medium-term shelter, or
    - stays in accommodation that falls below minimum community standards4, and
d) does not have the means to change their living arrangements.

At risk of homelessness definition

'At risk of homelessness' in the context of aged care and for the purpose of receiving Australian Government funded aged care services refers to an individual who:

a) is aged 50 or older, and
b) has prematurely aged requiring services for their aged care needs, and
c) is at risk of experiencing the following living arrangements:
    i. having no adequate roof over their head, or
    ii. having no security of tenure, or moves between various forms of temporary or medium-term shelter, or
    iii. staying in accommodation that falls below minimum community standards, and
d) does not have the means to change their living arrangements.

In the context of assessing eligibility criteria to receive Government funded aged care services under the Act, a homeless individual is someone who is currently without adequate, stable accommodation or accommodation that meets minimum standards, has no means to change their living arrangements, is at least 50 years old, has aged care needs and has prematurely aged due to experiencing homelessness, resulting in a need for aged care services.

In the context of assessing eligibility criteria to receive Government funded aged care services under the Act, an individual who is at risk of homelessness, may currently be housed, however is in such a vulnerable position that it is reasonable to expect they will soon experience homelessness (without adequate, stable accommodation or accommodation that meets minimum standards), has no means to change their living arrangements, is at least 50 years old, has aged care needs and has prematurely aged due to experiencing homelessness, resulting in a need for aged care services.

Eligibility criteria assessment

An individual is considered homeless or at risk of homelessness and eligible for Australian Government funded aged care services if all the following conditions are met:

1. **Age:** the individual is aged 50 or older.
2. **Aged care needs:** the individual has aged care needs requiring personal or clinical care, or both, due to difficulties performing daily living activities and requires assistance to maintain their capacity to function independently.
3. **Prematurely aged due to experiencing homelessness:** the individual's aged care needs are equivalent to those of someone aged 65 or older and has aged prematurely due to experiencing homelessness.
4. **Living arrangements:**
   a) For homeless individuals: the individual lacks secure, fit and adequate housing, or housing that meets minimum living standards from a community or human perspective.
   b) For at risk of homelessness individuals: the individual is at imminent risk of lacking secure, fit and adequate housing, or housing that meets minimum living standards from a community or human perspective in the near future.
5. **Financial resources:** the individual has limited or no financial means, resources or access to any sort of funding that would enable them to change their housing situation. The financial hardship often reflects a lack of control arising from their life circumstances.
6. **Choice and consent:** the individual does not choose to be homeless and consents to accessing Australian Government funded aged care services, particularly entering residential aged care.



Note:

If an individual has an aged care needs assessment between 50 and 64 years under the homelessness and risk of homelessness eligibility criteria, and is approved for aged care services, they are also eligible for reassessment before they turn 65 at a later date, regardless of whether the eligibility criteria applies.



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

5.2.4. Informing the eligible younger person of other services

If the individual is under the age of 65 and falls into one or more of the eligible cohorts, they must inform the eligible younger person of other services that may be available to meet their care needs, noting that it is not a requirement for a person under the age of 65 to take up other services in place of aged care services.

> Note:
>
> Eligible younger people who have been referred via the My Aged Care contact centre or an ACSO would have been informed of other services prior to agreeing to be referred for an assessment. Triage Delegates should check the eligible younger person's record to confirm whether they have been advised of other services at the screening stage.

If the eligible younger person advises that they do not wish to explore other options, proceed with triage as usual.

If they indicate they would like the opportunity to explore alternative support options, they can be referred to the services list below at *Figure 3*, where applicable and relevant to their local area. If they choose to pursue this pathway and do not want to be referred to an assessment organisation, triage should not continue, and the assessment can be cancelled. A Notice of Decision does not need to be issued as the application has been withdrawn.

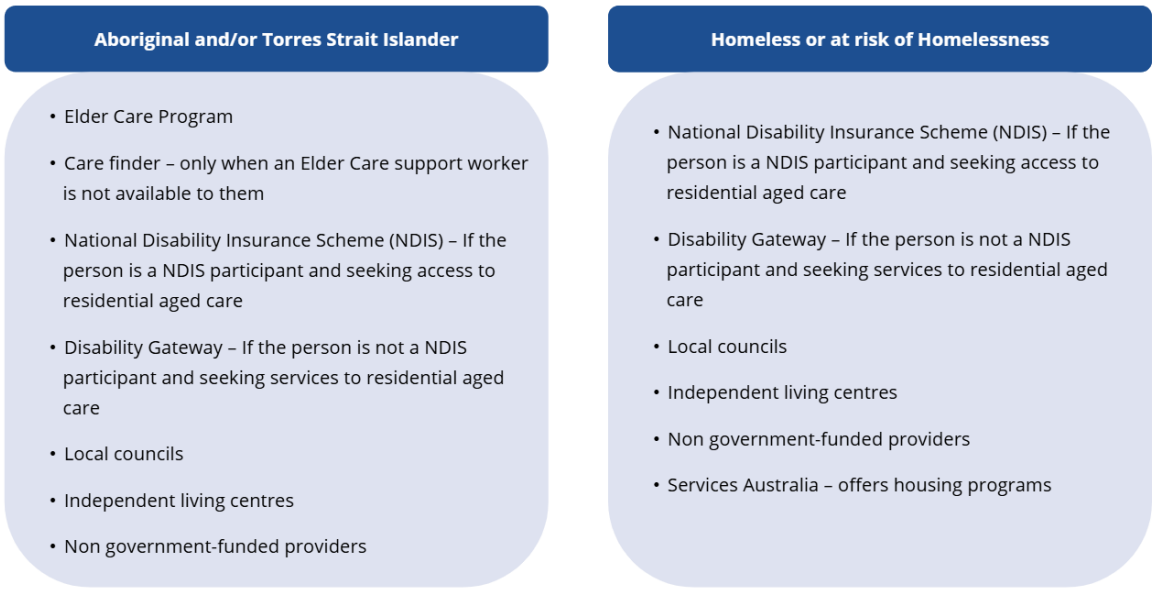


Figure 3 – list of alternative options for the eligible younger person to consider

5.3. Conducting triage

Note

Only appropriately qualified and certified assessment staff can hold the triage delegate role and undertake triage. Please refer to *training requirements for assessment teams* in Chapter 2 and *Aged care assessment workforce minimum qualification requirements* in Appendix F

Prior to calling the older person to conduct triage, Triage Delegates should:

Review the older person's My Aged Care record

- Note the older person's preferences, choices, any additional needs and communication preferences that will need to be accommodated during the assessment process (e.g. when a hearing impairment is identified or an interpreter is required)
- Note that information will be pre-populated from screening. In some circumstances, if an older person was previously found ineligible, then later is eligible, the screening information cannot be changed. The 'likely ineligible' flag will be unticked however screening information will not be able to be updated.
- Where the older person has nominated a primary contact, and the triage delegate is satisfied that the older person nominated this person to be contacted in place of the older person in all instances (or the primary contact has nominated themselves because they are an appointed decision maker recognised under the Act with relevant legal authority for the older person), the triage delegate can contact the nominated primary contact in the first instance. This may be to inform the primary contact that the delegate is seeking to conduct triage, what triage would involve, and to ask the primary contact to discuss the process with the older person. An older person is encouraged to be present for triage, but this is not necessary if the primary contact either:
    - can communicate information for the older person, including in their capacity as an agent or a registered supporter, or
    - is an active, appointed decision maker for the older person recognised under the Act and has legal authority to make decisions relevant to triage on behalf of the older person.
- If the triage delegate is contacting the older person's appointed decision maker, the triage delegate must ask them to confirm:
    - that they are acting in line with their legal authority to make decisions for the client (mandatory), and
    - if they have talked to the client about the triage and what it may involve (not mandatory, but this is in line with the principles of supported decision-making).

Note:

Registered supporters must act only within the scope of their roles. For example, the role of a registered supporter is to support the older person to make and communicate their own decisions, acting in line with the known will and preferences of the older person. Triage delegates should check that a registered supporter or agent is communicating information for the older person in line with their role, not making decisions on behalf of the older person. If in doubt, the triage delegate should contact the older person.

If an active, appointed decision maker recognised under the Act (whether or not registered as a supporter), is making a decision on behalf of an older person, triage delegates must be satisfied that the appointed decision maker is acting in line with their legal authority under a Commonwealth, state or territory arrangement, and that the authority is relevant in the circumstances.

Triage Delegates should review the proof an appointed decision maker has provided to the System Governor to support their authority. A Triage Delegate cannot rely solely on a person's registration as a supporter to assume their decision-making authority for aged care triage or assessment matters or assume that simply because a person has a supporter guardian, the older person does not have decision-making capacity for some or for all matters.

Triage Delegates should also inform the appointed decision maker that it is preferred, where possible, that the older person is present on the call.

If any information or documents must be shared with an older person during the triage process, it must also be shared with certain registered supporters (supporters and supporter guardians) for an older person, in line with the Act (section 29). Information cannot be automatically shared with an older person's 'supporter lite.'

Triage delegates must consider a referral to care finder services for a vulnerable older person who does not have anybody who can support them. Information on care finder services is available at My Aged Care. For Aboriginal and Torres Strait Islander clients, the assessor may also connect the older person with an Elder Care Support worker to provide additional support to the older person.

From 29 June 2026, a new pathway in the My Aged Care Assessor Portal will allow a Triage Delegate to determine that a client is not eligible for assessment without completing the triage process. Where a client is clearly ineligible (for example, due to age), the Triage Delegate can use the 'Decide Not Eligible' function in the My Aged Care Assessor Portal to record the decision without completing the triage section of the Assessor Portal. They must select the reason the client does not meet the eligibility criteria and will then be directed to the attachments tab to generate and upload the ineligibility letter. Clients found ineligible at triage must be issued an 'Ineligible for Assessment' letter, which must be uploaded to the client's online record.



- Help from a care finder | My Aged Care
- Elder Care Support program | My Aged Care

5.3.1. Initial discussion

When contacting the older person and/or nominated contact, triage delegates should:

- Identify who they are and the organisation they are from and confirm that they have 15 to 20 minutes to discuss their assessment request.
- Complete an identity check and confirm whether there is anyone else with the older person at the time (e.g., registered supporters, family members). If they do not have

anyone with them and would like someone with them, call back at a more suitable time.

- Advise they have received the referral, who it is from and the role the assessment organisation plays.
- Advise they will be asking a few questions relating to their general health and wellbeing to help inform assessment needs.
- Confirm consent (consistent with section 5.1) and ensure the older person understands why they are having the assessment, why the assessor needs to come to their home (if applicable) and allay any concerns or fears that they may have about the assessment. Should the older person or their active, appointed decision maker recognised under the Act choose not to give consent, the triage process is to end, and the assessment referral is rejected.
- Confirm their preference for an Aboriginal and Torres Strait Islander assessment organisation (see below this section for further detail).
- Check the contact information for the older person, and if appropriate, the contact information for the registered supporter or agent, such as a care finder (including address for receiving correspondence) to ensure it is complete, correct and validated.
- Gather any additional information required, including whether the older person would like someone who supports them/registered supporter/agent present for the triage questions asked using the Integrated Assessment Tool or at the assessment.
    - If an older person lacks decision-making capacity, an active, appointed decision maker recognised under the Act (whether or not a registered supporter) must be involved in the assessment to ensure the older person is accurately assessed. An active, appointed decision maker for this purpose may already be identified on the older person's record as a person to whom all correspondence must be sent. Triage delegates should review the proof an appointed decision maker has provided to the System Governor to support their authority. Registered supporters who are not active, appointed decision makers can also be involved, in line with the will and preferences of the older person. The assessor can submit a request to create a new registered supporter/agent relationship if required (see Chapter 3).
    - Submitting a 'request' may mean a supporter relationship is recorded in the system as a pending relationship seeking to be registered by the System Governor. There are many ways to submit a request, including with the help of an assessor, online, by calling My Aged Care, or using a printed registration form. More information on the registration pathways is available at: www.myagedcare.gov.au/registering-supporter.
    - A person who is seeking to become a registered supporter and wants to rely on their authority as an active, appointed decision maker to become registered, must provide proof to show they are an active, appointed decision maker for the older person. This is likely to be legal documentation. Medical evidence may also be required to establish that the older person is experiencing a loss of decision-making capacity.
- Organise an interpreter if required (e.g., for interpreting services or Auslan) and ensure other necessary supports are in place for the assessment.

- Acknowledge that multiple contacts with older Aboriginal and Torres Strait Islander people may be required to build trust and rapport but this should not compromise on older people being able to access timely aged care services.

Note:

An interpreter may need to be pre-booked, so early action on interpreter arrangements will assist meeting timeliness measures.

- There are several support networks that the triage delegate can refer to for older people who are more vulnerable or hesitant to participate. These include:
  - Home - OPAN
  - Support for people who are from culturally, ethnically and linguistically diverse backgrounds | My Aged Care'
  - Getting support in aged care | My Aged Care
  - Help from a care finder | My Aged Care
  - Elder Care Support | Australian Government Department of Health, Disability and Ageing
  - Support for people who are lesbian, gay, bisexual, transgender or intersex or other sexual orientations or are gender diverse or bodily diverse | My Aged Care
- Consider asking the older person if they have a My Health Record to help ensure their Support Plan can be linked to it (subject to their consent, as per section 5.1).

Confirming a client's preference for an Aboriginal and Torres Strait Islander assessment organisation

A client's preference for an Aboriginal and Torres Strait Islander assessment organisation, will usually be captured at registration. The client's preference will be visible on their client card.

It will need to be confirmed when completing the client's demographic details at triage.

- When a triage delegate receives a referral, they should view the client information to gain a preliminary understanding of the client's situation.
- If there is no preference listed, please record the preference after having a conversation with the older person.

It is important to have a conversation with the older person about their preference. It should not be assumed that all Aboriginal and Torres Strait Islander people will want their assessment with an Aboriginal and Torres Strait Islander assessment organisation.

- The client's preference will determine whether the referral is accepted, transferred or rejected.
- If a transfer is required, this will need to be managed with the support of a Team Leader.
- It will also ensure that the assessment process is responsive to the person's individual situation.

Asking triage questions using the Integrated Assessment Tool

The triage component of the IAT helps validate the appropriateness of an assessment referral and to collect information to support the assessment process. Triage delegates must refer to the IAT User Guide to ensure competency in the use of the IAT and in the delivery of high-quality triage. Triage delegates are also required to complete mandatory online induction training and triage delegate training before undertaking the triage component of the IAT.



See the IAT User Guide for further information.

Triage delegates will be able to choose whether information gathered at screening is pre-populated into the triage component of the IAT. Pre-populating information will help reduce the older person's need to repeat their story.

The triage component of the IAT comprises questions relating to the reason for their assessment, current access to services, function, general health and general wellbeing and safety.

When conducting triage with older Aboriginal and Torres Strait Islander clients, a triage delegate should exercise discretion and professional judgement on how information is solicited from clients during the triage process. This includes ensuring that information is collected in a culturally safe manner. including the appropriate use of the IAT. A yarning approach may be employed to collect the necessary information and with consent from the older person, support persons may be present during the Triage process.

Where possible, the triage delegate should liaise with the client's GP, service provider and support networks to help inform the triage process. The approach allows relevant information to be gathered in advance and confirmed during triage, reducing the need for the client to repeat their story multiple times.

> Note:
>
> For referrals for the End-of-Life Pathway, triage questions will be optional so there is flexibility to only ask questions that are appropriate to the individual.
>
> When completing the Triage section of the IAT, the triage delegate must provide clear justification in the 'Outcome/advice for assessment notes' field to support the recommended assessment type. This justification should explain why the selected assessment type is appropriate.

At the conclusion of the triage component of the IAT, triage delegates will confirm eligibility for an assessment, the assessment type, assessment priority and whether urgent services and/or linking supports are required, in instances where these services were not provided at screening. In the case of End-of-Life Pathway referrals, if an End-of-Life Pathway Form has not already been submitted, the triage delegate should advise the older person of the steps required. More information on the End-of-Life Pathway Form is included under section 5.3.4.

If the Triage Delegate disagrees with the assessment type and/or priority recommendations made at the screening stage, the triage delegate will have the ability to change the recommendations.

After triage, the team leader may also transfer the older person to another assessment organisation if appropriate. The team leader should ensure the older person understands why they are being transferred, and that the receiving assessment organisation is aware that they will receive the referral.

> Note:

If the older person is deemed to be ineligible for a needs assessment, the triage delegate should communicate the decision and inform them how to request an assessment in the future (this can occur at a separate time to the initial phone call, if necessary).

Effective communication with the older person (and their active, appointed decision maker or registered supporter, where appropriate) on a decision to not recommend an assessment, and effective communication between assessors, assists with managing expectations and reducing complaints.

An 'Ineligible for Assessment Letter' will need to be sent to the older person (and registered supporters, as required under the Act) as notice of this decision.

Within the IAT, the triage delegate will be able to consider the type of assessor recommended for the older person's assessment, having regard to:

- relevant cultural background or understanding
- who has the expertise to address the diverse needs of the older person, such as part trauma
- who is geographically closest to the older person, which helps to ensure the older person is assessed in the most efficient, effective and timely manner.

5.3.2. Referring for urgent services and linking support at triage

Triage delegates are responsible for determining whether individuals require referrals under the Alternative Entry Pathway. This allows clients to access services prior to undergoing an assessment.

The triage section of the IAT includes a question about an older person's need for urgent service provision; *Does the client require urgent service provision (direct to service)?* This is a mandatory question and requires a *Yes* or *No* answer and details must be added to a free text box. This question is used to determine the need for urgent services via the Alternative Entry pathway. Information on issuing referrals under the Alternative Entry Pathway is included in Chapter 3.

Even if the urgent services are only required for a short period, the older person will still be required to undergo an assessment.

The triage delegate may also identify and recommend linking supports for the older person following triage, or for consideration by the assessor at assessment.

5.3.3. Triage for clients who have been referred through a support plan review

In submitting a request for a reassessment following a SPR, the assessor will be able to update the triage section of the Assessor Portal and should enter as much information as they can while conversing with the client at the end of the SPR.

The triage delegate should consider the information entered in the triage section of the Assessor Portal by the assessor, and if satisfied can complete the triage questions in the Assessor Portal, without needing to speak with the client, given this occurred at the SPR

stage. An assessment can then be scheduled for the client at a time that aligns with their priority setting.

Where this occurs, consent to complete triage questions must be sought by the assessor when the assessor is speaking with the client (or their registered supporter and/or appointed decision maker) at the SPR stage.

If a conversation with the client has not occurred at the SPR stage, the triage delegate should speak with the client to confirm a significant change has occurred, drawing on the triage questions to inform response. If the triage delegate is satisfied a significant change has occurred, they should complete the triage questions and recommend a reassessment.

5.3.4. Conducting triage for the End-of-Life Pathway

The End-of-Life Pathway is available to participants already accessing Support at Home as well as older people who are not currently accessing services through the Support at Home program.

A participant can access one episode of the End-of-Life Pathway through the Support at Home program. An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- a medical practitioner or nurse practitioner provides an estimated life expectancy of 3 months or less, and
- a score of 40 or less on the Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator)

Older people who are not currently accessing Support at Home, who would like to access the End-of-Life Pathway, can be referred for a high-priority aged care assessment.

The End-of-Life Pathway Form must be completed and validated before End-of-Life Pathway can be approved. The form captures specific medical information related to the participant's medical condition and evidence of end-of-life. An appropriate medical practitioner (their GP, non-GP specialist or nurse practitioner) will complete the form.

The assessment referral will follow the same process as it does for all assessments and will be assigned by a Team Leader for triage.

All triage questions will be *optional* for the End-of-Life Pathway so there is flexibility in only asking questions that are appropriate to the individual. Questions that would be insensitive to ask during triage can be skipped.

The End-of-Life Pathway Form does not need to be submitted for the triage delegate to complete triage and assign the assessment to an assessor. If an End-of-Life Pathway Form has not already been submitted, the triage delegate should advise the older person of the steps required (e.g. downloading the form and visiting their GP, non-GP specialist or nurse practitioner to have the form signed).

In cases where an aged care assessment or support plan review (SPR) will be undertaken via telehealth, assessors will need to assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options for submission is included in section 0.

For participants seeking access to the End-of-Life Pathway who have submitted their End-of-Life Pathway Form at this stage, triage may also involve verifying this documentation.

If a Triage Delegate identifies a submitted End-of-Life Pathway Form contains a mistake or missing information, triage should still be completed and the older person should be progressed to an assessment, while keeping the form as not validated. An older person should be informed the form contains missing or mistaken information and what they need to do for the form to be fixed. Once fixed, the form can be presented for validation at assessment.

The Triage Delegate can flag a referral as End-of-Life before or after (not during) triage by clicking the 'Flag as End of Life.'

To access the End-of-Life Pathway, existing Support at Home participants can request an urgent support plan review.

5.3.5. In-hospital triage and self-referrals

For hospital assessments, in the first instance an assessor, once obtaining the older person's consent, will complete the triage questionnaire using clinical records and information that is available, in liaison with the hospital discharge team. Note, if the older person is currently receiving aged care services the Function, General Health, and General Wellbeing and Safety sections of the triage questionnaire are optional. Following triage, the assessor may recommend a high or medium priority assessment.

Where an assessment is self-referred, and the assessor is with the older person, assessors will be able to conduct triage with the older person at the same time as the assessment. For assessors who are not Triage Delegates, triage must be conducted with triage delegate oversight.

5.3.6. Recording eligibility for an assessment for individuals aged 50-64

When determining whether an individual aged 50-64 years is eligible for an aged care needs assessment, triage delegates should clearly record their decision and the information they relied upon to come to that decision. This should be recorded in the free text box at the end of the triage section. For example, when finding someone aged between 50-64 is eligible for an assessment under the homeless/risk of homelessness provisions of the Act, the triage delegate should make specific reference to which criteria under the relevant definition applies to the individual who is seeking an assessment. Refer to section 5.3 of this Manual for the definition of homeless and risk of homelessness.

The free text box at the end of the triage section of the Assessor Portal should also be used by the triage delegate to record confirmation an individual aged under 65 has been informed of other services that may be available to meet their needs before electing to be provided funded aged care before the age of 65.

> Note:
>
> Triage Delegates should review the 'client story' note in an older person's record to confirm if an eligible person aged 50-64 has been informed of other services that may meet their needs during screening.

5.3.7. Preparing an older person for their assessment

Triage delegates should outline to the older person what will happen at the assessment, discuss their availability for the assessment and then make the appointment. Where possible, the triage delegate should give the name of the assessor that will be undertaking the assessment.

Additionally, triage delegates should:

- Complete the Work, Health and Safety (WHS)/Home Safety Risk screen and check for alerts and notes in the referral information on the My Aged Care record. Ask relevant questions to identify work, health and safety concerns which could affect the assessment for example: “Are there any risks or hazards the Assessor needs to be aware of before attending the assessment in your home?” The team leader may already have knowledge of information that may be relevant to assessment services and assessor safety.

Note: Special WHS requirements (such as the necessary presence of the older person’s guide dog) at the assessment. Arrange other responses (such as the need for two assessors to attend the assessment due to safety concerns).

- Upload any additional older person information to the older person record (e.g., WHS screen) and use ‘Notes’ to record assessment booking details. Include if relevant, with older person’s consent, sensitive information in sensitive notes and attachments.

- Check to see if there are cohabitating older people in the house who may also require an assessment and refer them to My Aged Care or include a note that they may be self-referred to their assessment organisation if circumstances meet the self-referral criteria and if appropriate.

5.3.8. Preparing for an assessment with an older Aboriginal and Torres Strait Islander person

Taking note of the community the older person belongs to, assessors can support culturally safe and appropriate assessment practices. This information may help ensure the referral is assigned to an assessor who is either from the same community or has a strong understanding of the local customs and cultural context. This alignment may enhance the delivery of culturally safe, trauma aware and healing informed assessments.

In preparation for the assessment, the assessor/triage delegate should collect as much relevant information as possible prior to the assessment. This helps to inform the process and reduces the need for the older person having to re-tell their story.

Where consent is obtained from the older person, this may include:

- information collected by the Elder Care Support workforce
- Information from GPs or the Aboriginal Torres Strait Islander health/medical services, including results from MBS 715 health check
- Information from other health professionals, where appropriate

Once triage is finalised and the assessment assigned to an assessor, the answers to triage questions cannot be altered by an assessor. Assessors and team leaders will be able to access historical triage information on an older person's record, which includes details such as the dates of previous triage, the organisation and individual who conducted it, and the outcomes of the triage.

Where possible, Aboriginal and Torres Strait Islander people should be matched with an assessor who is appropriate as per the local customs, protocols, kinship obligations and preferences of the older person. This may include the support of family members or advocates where appropriate.



Department of Health, Disability and Ageing website:

Deaf Connect (free face-to-face sign-language and Remote Video Interpreting Service)

Fact sheet for Assessors on care finders

My Aged Care website: Support for Hearing and Vision Impairment;

Help from a care finder

5.4. Revoking eligibility during an assessment

An individual's eligibility to undergo an assessment is determined by a triage delegate based on the information available to them when triage is conducted. The Act provides specific circumstances where an eligibility decision may be revoked on the initiative of the System Governor, including during the application process the individual gave information or documents which were false or misleading, omitted any matter or things that without would make the document false or misleading. This may include situations where key facts presented were inaccurate or misleading, resulting in the eligibility decision being granted erroneously. In such cases, it is the departmental delegate's responsibility to assess the evidence, and if warranted, initiate the revocation process to maintain the integrity of the aged care system.

If an assessor or assessment delegate has concerns about the information or documents provided by an older person and/or their registered supporter(s) or appointed decision makers, they should contact their assessment organisation's operational manager, who will make contact with the relevant area of the Department to resolve.

For further information on revocations on the initiative of the System Governor and individual, please refer to Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints.

5.5. Assessment settings

5.5.1. Usual accommodation setting

An initial assessment should be face-to-face in the older person's usual accommodation setting. This will assist with the environmental, physical, and social components of the assessment by observing the older person's level of independence, functioning, and

existing support arrangements in familiar surroundings. Due to the nature of transition care services, some assessments will occur in the hospital setting.

However, if this is not possible, assessments for Aboriginal and Torres Strait Islander people should be undertaken at a setting that makes the older person feel safe, at ease and comfortable.

Assessing an older person who is not in their usual accommodation setting

When assessing an older person who is residing in a residential aged care or hospital setting for services to support their transition to residing in the community, the assessor can still complete a 'true' assessment based on their best efforts to understand and assess against the person's functional needs in the community setting they intend to reside in not the setting where the assessment is being carried out. in these circumstances, it may be necessary for assessors to seek information about the older person's home environment from the older person's care and support team to make an as accurate assessment as possible of their functional needs.

5.5.2. Telehealth

It is best practice for assessments to be conducted face-to-face. Assessment organisations are strongly encouraged to ensure assessments are face-to-face wherever possible. Where face-to-face contact between the assessor and older person is not possible (e.g., when assessing an older person in a remote area or the older person is inaccessible due to exceptional circumstances such as a seasonal weather event), a telehealth assessment may be undertaken. Where a telehealth assessment is proposed by the assessor, it is important that they explain to the client the rationale of using that assessment setting and any implications this may have such as timing, the potential need for other people to be involved before, during and/or after the assessment and logistical considerations such as organising video call capabilities.

The assessor must make additional efforts to ensure the quality of assessment is not compromised when conducting a telehealth assessment and that assessment decisions remain evidence based.

Another suitably qualified person (such as a local health worker) and/or the older person's agent, registered supporter or appointed decision maker may attend the assessment with the older person to assist the assessment process.

If a local health worker or provider is involved, and with consent from the older person, the assessor may, work with these individuals prior to an assessment to attain relevant information that can help inform the assessment process.

In cases where an aged care assessment or support plan review (SPR) will be undertaken via telehealth to assess eligibility for the End-of-Life Pathway, assessors will need to assist older people to ensure the completed End-of-Life Pathway Form is submitted. More information on options for submission is included in section 6.3.1.

5.5.3. Remote setting

Assessors should use the remote assessment indicator in the My Aged Care assessor portal to indicate if an assessment has been or will be conducted in a remote area. This

indicator can be checked before starting an assessment, when uploading from the Aged Care Assessor App or on finalisation of an older person's Support Plan.

The Department uses the Modified Monash Model (MMM) as the classification system to define geographical remoteness. The remote assessment flag should only be selected where a face-to-face assessment is undertaken in a remote (MM6) or very remote (MM7) area. You can check the MMM classification by entering their address in the department's Health Workforce Locator.



My Aged Care – Assessor Portal User Guide 6 – Completing an assessment

5.5.4. Hospital setting

Assessments in a hospital setting are typically conducted by a clinical assessor.

For those older people in hospital requiring an assessment, they should be assessed in the same way as those assessed at home, utilising the IAT to ensure a nationally consistent approach to assessment of aged care needs, including consideration of the home environment and social issues. An older person needs to be in a stable condition for a hospital-based assessment to take place (unless a rapidly deteriorating condition makes this impossible). Being medically stable ensures that the care needs of the older person outside of the hospital can be accurately assessed and the most appropriate care services recommended.

In hospital assessments, the assessor must ensure that a carer or other advocate is advised of the assessment in all circumstances and should be present during an assessment where possible.

Approvals for all types of care can be made following an assessment in a hospital environment (e.g. an assessor can recommend for Assessment Delegate to approve CHSP). There should be no presumption that older people will progress from hospital to residential care, as they may be able to return to their previous living arrangements. This is especially appropriate following an acute incident where the individual may benefit from a reassessment in the home environment after the acute phase.

Assessors need to be aware that for an older person to be approved for TCP, the assessment must be conducted while the person is in hospital. Assessors should also consider arranging an assessment for Support at Home or CHSP when the older person is discharged from a hospital and returns to their usual accommodation setting. This allows a more accurate picture of care needs in the home setting and ensures the older person's current needs and goals are being assessed.

Assessors should be aware that a person being assessed in a hospital setting cannot be approved for the Restorative Care Pathway or a period of reablement.

5.6. Commencing the Assessment

Note
Only appropriately qualified and certified assessment staff can hold assessor roles and undertake assessments. There are different credentials for clinical and non-

clinical assessors. Please refer to training requirements for assessment teams in Chapter 2 and Aged care assessment workforce minimum qualification requirements in APPENDIX F – Aged care assessment workforce minimum qualifications.

Assessors are required to do the following prior to attending the assessment:

- After the referral has been assigned to the assessor, the assessor must review all information in the older person's record.
- With the older person's consent, consider the collection of information on the older person's situation and medical conditions diagnosed by suitably qualified medical personnel that may be required prior to the assessment. Contact the referrer or health professional if indicated prior to the assessment.
- Note and manage WHS risks.
- Note the timeliness measure for completion of the assessment process.
- Determine whether a culturally appropriate support person, interpreter, care finder, elder care support worker or advocate (through OPAN for example) needs to be included in the assessment.
- Gather any anticipated forms or resources, including providing copies of relevant My Aged Care booklets and/or brochures depending on the type of assessment to be conducted.
- Review *Best practice tools and tips for conducting the assessment* in this manual for guidance on how to achieve a conversational, respectful, and empathetic approach during the assessment. This will allow the assessor to develop rapport with the older person and their support network.
- Download the assessment if using Aged Care Assessor App.
- Check whether a supporter or agent for the older person has been registered or established. If the client is already registered in My Aged Care, assessors can do this by using the assessor portal to find the client, then view their support network (if any supporter relationships have been registered). Refer to Chapter 3 for information on how registered supporters must engage with the older people they support, and how they might be involved in an assessment.
- Check the authority of any active, appointed decision makers of the older person, if they have made themselves known to the assessor or My Aged Care. Appointed decision makers are not required to register as supporters to exercise their legal authority under a Commonwealth, state or territory arrangement. However, this is encouraged to streamline authentication and information sharing to support older people. Assessors can engage with active, appointed decision makers before, or without them, formally registering as supporters, provided the assessor is satisfied they are acting within their authority recognised under the Act. To do so, assessors should seek legal documentation that shows the person is an active, appointed decision-maker for the older person and that their decision-making authority is relevant to the assessment. Medical evidence about the older person may also be required to show that the decision maker's authority is active.
- Review notes entered at triage including referrals, attached documents and previous support plans if applicable, to help familiarise yourself with the older person and their needs and limit the need for the older person to repeat their story.
- Connect with the local Aboriginal and Torres Strait Islander community with their knowledge of local services and culture.
- It is recognised that building rapport and trust with older Aboriginal and Torres Strait Islander clients may require multiple contact attempts, particularly for individuals who have experienced trauma or institutionalisation. Assessment organisations should make all reasonable efforts to engage with the client in a

respectful and culturally safe manner with their advocate if they have identified they are in contact with one.
- Assessment organisations are encouraged to consider culturally safe engagement strategies, such as involving trusted agents like Elder Care Support workers or other appropriate advocates as well as arranging face to face contact where possible.

5.6.1. Confirming an older person's preference prior to the assessment

As it is a phased rollout, Aboriginal and Torres Strait Islander people who are booked with a Single Assessment System organisation need to have the choice to transfer their assessment to an Aboriginal and Torres Strait Islander assessment organisation if one commences in their area.

Preferences for an Aboriginal and Torres Strait Islander assessment organisation should be uncovered during the assessor's pre-assessment planning. This allows the assessor time to contact the client, discuss their preference and organise transferring the client prior to the assessment commencing.

- If the preference is identified at the start of the assessment, the assessor may wish to explain to the client that making a referral to an Aboriginal and Torres Strait Islander assessment organisation may cause a delay with them receiving their current assessment or an Aboriginal and Torres Strait Islander assessment organisation is not yet available in their region. Subject to the client's agreement, the general recommendation would be that the assessor with the booking continues with the assessment as planned. However, if the client still does not wish to proceed with the assessment, the assessment will need to be cancelled.
- The client's condition needs to be taken into consideration, that their health condition and care needs would not be adversely impacted by a delay in assessment if they were to be referred to another organisation.
- A conversation with the client prior to the assessment is recommended to ensure that they have choice and control and the ability to make decisions regarding their care.
- If the client's preference is to be assessed by the Aboriginal and Torres Strait Islander assessment organisation; and they understand the timing impacts; then the assessor can ensure a warm referral. The assessor may contact an Aboriginal and Torres Strait Islander assessment organisation and where suitable the organisation may self refer the client.
- A rejection reason 'client prefers a FNAO' is available in the My Aged Care Assessor Portal. An older Aboriginal and Torres Strait Islander person should not be rejected based on a client's preference unless it is a last resort. A transfer prior to the assessment is preferable to a rejection.
- If the referral is cancelled by the assessor at the point of assessment, this may slow down the process for the client which is not the desired outcome.

The above process also applies to support plan reviews, and subsequent new assessments.

At the time of the assessment, the assessor must:

- Be clear to the older person who you are and the organisation you are from and outline your role as an assessor on behalf of My Aged Care.

- Wear the My Aged Care badge or ID according to assessor branding protocols and style guide.
- Inform the older person of the assessment process and potential outcomes
- Conduct a wallet check:
    - explain to the older person why you need to do this
    - sight two valid identity documents
    - if the wallet check has been attempted but the older person is unable to produce two valid identity documents or has indicated they will provide documents at a later point, enter this information as a note in the older person record as evidence of attempting the wallet check
    - record the results on the older person's record.
- Confirm that the older person understands the role of the assessor and the assessment process and obtain the older person's (or, as appropriate, the active, appointed decision maker's consent, whether or not they are a registered supporter) before commencing the assessment. Explain to the older person that the assessment has now commenced as they have provided consent, and
- Confirm the identity of other people supporting the older person at the assessment, including the status of registered supporter and agent relationships
- Submit requests to register supporters/agents as required and when practical, ensure any supporting documentation is uploaded, including legal documentation and medical evidence if required.
- If the assessor is an Enrolled Nurse conducting a comprehensive assessment, they must be under direct or indirect Registered Nurse supervision within the same organisation.

Note: The older person can withdraw their consent at any time. In this case the assessment is discontinued.

5.6.2. Wallet check

A wallet check assists to verify the older person's identity and reduce the risk of duplicate records. Whoever has the first face-to-face contact with the older person following the creation of the older person's record (e.g., an assessor or service provider) is expected to sight two types of valid older person identification and record this information on the older person record. The My Aged Care assessor portal provides a list of types of identification that can be used for the wallet check.

The wallet check only needs to occur once. If a reassessment is being conducted for an older person who has previously had a wallet check it is best practice for the assessor to check the older person's identification and confirm their details have not changed. Where possible assessors should use the wallet check as an opportunity to confirm an individual's age provided at screening or triage matches the age on their identification. If there are concerns that an individual does not meet the age eligibility requirement or one of the exceptions to undergo an assessment based on identification cited during a wallet check, the department should be contacted.

Note:

The wallet check can be conducted at any stage of the registration or assessment process and through the Aged Care Assessor App.

5.6.3. Registering a supporter

Registered supporters help older people to make and communicate their own decisions about aged care. A registered supporter can request and receive information about an older person's aged care, help them to understand information and make their own decisions, and let people like My Aged Care and aged care providers know what the older person's decisions are.

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

- completing the Registration of a Supporter form. The assessor can upload the form and any associated documentation to the client's record. **Note:** a registration form may also be generated following the completion of the online registration form through the My Aged Care website. This will look different to the Registration of a Supporter form but should have all the same information. Assessors should treat it the same as the Registration of a Supporter form.
- submitting a registration request online with the assessor via the assessor portal or app, including uploading any associated documentation. If necessary, the Aged Care Assessor App camera can take a photo of document/s to upload as an attachment as long as the document photographs are clear and readable.

A completed registration form and any associated documentation can be uploaded to the client's record. The prospective supporter can also mail a copy of the documents to My Aged Care , and the assessor can write a note in the older person's record of this undertaking (see APPENDIX B – Contact details.)

Note:

Updated consent scripting and declarations for the registration of a supporter must be used by assessors if they are assisting an older person or prospective supporter through the registration process. These will be available on the Assessor Portal or App, and the printed Registration of a Supporter form.

Assessors must not use scripting or forms previously used for the appointment of regular or authorised representatives, as these are not relevant to the registered supporter role.

It is important to note that while assessors can collect and submit the required information, they may not be able to confirm or approve the registration of a supporter relationship, depending on the circumstances. For example, some applications must be escalated to the departmental team responsible for supporters to consider before a decision to register can be made. This includes applications:

- where the prospective supporter has declared a conflict of interest
- where there is anything to suggest the prospective supporter cannot comply with the duties of a supporter (e.g., the prospective supporter is currently suspended or had a previous registered supporter relationship cancelled), or
- where the prospective supporter wishes to rely on their authority as an appointed decision maker recognised under the Act and must provide additional

documentation like legal and medical evidence. These documents must be submitted to, and validated by, the departmental delegate responsible for supporters.

The My Aged Care website includes information on the various ways a person can request to register, or become, a supporter.



My Aged Care - Registering a Supporter

My Aged Care - Registered Supporter Resources.

If, in submitting a request to register a supporter who wishes to rely on their authority as an appointed decision maker recognised under the Act for the older person, proof of legal decision-making authority cannot be obtained, advise the pending registered supporter to provide the required proof, including any legal or medical documentation to the delegate team responsible for registered supporters. This team will process the documents and if validated, register the relationship.

5.7. Undertaking an assessment using the Integrated Assessment Tool

The assessment starts with getting the older person's consent. Consent from the older person, or their active, appointed decision maker recognised under the Act is recorded on the IAT. The IAT is an assessment tool that has been designed to support skilled assessors to assess a client's aged care needs. It comprises questions across social, physical, medical, cognitive, and psychological domains as well as home and personal safety, risk of vulnerability and support considerations.

The IAT is divided into thirteen sections. Some sections of the IAT contain nested questions to tailor assessments, only diving deeper into areas where needed. This means that some question sets or validated tools in the IAT will only display to the assessor if certain answers are selected to the question directly proceeding it. The IAT integrates eleven validated tools directly into the assessment process, enhancing the depth and clinical relevance of the assessment.

Assessors may wish to use assessment tools not included in the Validated Assessment Tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation. Each assessment organisation is responsible for providing their assessment staff with training on how to use these Validated Assessment Tools. General information about each tool is provided in assessor induction training but additional training provided by the assessment organisation is recommended to make sure each assessor understands the results from each validated tool.

The IAT includes decision support rules to assist assessors to make recommendations for the type of support an older person requires based on the older person's responses to relevant questions.

In completing the IAT, the assessment information should include:

- evidence that the assessor has explored the older person's own supports and/or non-funded services (e.g., state and local government programs, private services) as options to help maintain their independence.
- evidence that the assessor has explored, observed and understands the older person's needs, concerns, strengths and goals to justify the assessor's recommendations for all aged care services.
- evidence of supporting an older person's communication or support person needs.
- a completed 'Support Considerations' section to demonstrate an understanding of what is important for the older person in regard to how support is provided, such as the below list (note some of these may be sensitive topics):
    - any cultural and/or religious values and beliefs
    - gender identity or sexual orientation/sexuality or experience of discrimination
    - history of childhood experiences
    - life experiences including traumatic events and associated triggers
    - other relevant information relating to parole conditions or other information that should be sensitively discussed with the older person when developing the Support Plan and that providers should be aware of.

The IAT User Guide provides assessors with further advice about each question in the IAT and possible answers. Assessors must refer to the IAT User Guide to ensure accuracy in the use of the IAT and in the delivery of high-quality assessments.

All mandatory questions must be completed, and it is best practice that the older person's concerns and goals are added before finalising the IAT. From 29 June 2026, there will be a prompt to remind assessors to add client's goals to the support plan before finalising the IAT to ensure an accurate assessment of a client's care needs. This is completed by navigating between the IAT and the support plan. This change is intended to improve the accuracy of a client's care needs, as information captured under concerns and goals can help inform a system prompt indicating whether a client may be suitable for Restorative Care. Assessors have the option to either accept or reject this prompt. If no client goals are required, assessors can still tick the check box in the prompt without navigating to the support plan and proceed to finalise the IAT.

The assessor then selects 'Finalise IAT' before moving to the support plan. This is so the ongoing home support Classification Algorithm can generate an ongoing home support classification level (IAT Outcome in the system), which may be a Support at Home classification or CHSP. A classification level recommendation must be made for people who choose to access services through the MPSP or NATISFACP.

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

Aboriginal and Torres Strait Islander assessment organisations will be required to use the IAT to conduct assessments and must do so in a way that is culturally safe for the region or older person. Assessors may conduct the assessment without a device. In such cases, the assessor should upload the information into the IAT when the assessment is completed. Assessors may also be able to make inferences from the yarn to complete the IAT.

Use the validated culturally appropriate assessment tools as needed (see the IAT User Guide for more information).

Note:

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

Important:

Under Support at Home, the care management supplement may apply to a registered provider in respect of an individual who is a care leaver. If applicable, the care management supplement will be credited to the provider's care management account.

To identify these individuals during the assessment, assessors must use the diversity fields in the IAT, which do not currently capture care leavers.

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

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

IAT User Guide

5.7.1. Clinical attendance

All sections of the IAT will be visible to both clinical and non-clinical assessors.

Where an assessment is initiated as a home support assessment by a non-clinical assessor and questions are triggered that require clinical judgement (referred to as clinical questions), the non-clinical assessor must arrange for the attendance of a clinical assessor to be involved in asking the clinical questions in the IAT. This process is known as clinical attendance and is supported by an assessment organisation's Clinical Governance Framework (see Appendix C for guidance) and standard operating procedures. This process helps to make it easier for an older person to have their needs fully assessed without delaying their assessment or having to be transferred between assessors. The clinical attendance process is outlined in detail below.

Clinical attendance in practice

When a non-clinical assessor triggers clinical questions in the IAT, a warning message in the My Aged Care Assessor Portal or Aged Care Assessor App will prompt the assessor to complete the section in accordance with their organisation's clinical governance

framework. If the assessor is using the IAT offline form, the clinical questions are colour coded in light pink.

Where clinical questions are triggered, the assessor must seek clinical attendance to ask the clinical questions (listed at Appendix D). Clinical attendance will need to be sought from a staff member who is assigned a clinical assessor role in the My Aged Care Assessor Portal. The ways in which clinical attendance can occur are detailed in the Table below and presented as tiers. Tier 1 is considered best practice; it is expected that an assessment organisation will adopt Tier 1 clinical attendance in the majority of cases.

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

For case studies of how clinical attendance will work in practice please see Appendix D.

Table 20. Clinical attendance procedure

Tier 1	A clinical assessor who holds a clinical assessor role in the My Aged Care Assessor Portal is available by video or phone call at the time the assessment is taking place to be involved in asking the clinical questions with the non-clinical assessor to the older person being assessed. A video call is preferable. The assessor can receive a call back when a clinical assessor becomes available. The assessment should continue while waiting for the callback. In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of any other clinical questions (see appendix D) and ensure that these questions are answered with a clinical assessor in attendance. There may be situations where it is not appropriate for the assessor to continue with the assessment, even with virtual, clinical attendance. This will be determined using the following criteria: • It is not physically or psychologically safe for the older person to continue the assessment, • It is not physically or psychologically safe for the assessor to continue the assessment, • The older person's condition requires a clinical assessor to undertake an end-to-end assessment

	Where it is considered inappropriate to continue, the assessment will end and a team leader will reassign the incomplete assessment to a clinical assessor to undertake.
Tier 2	There may be circumstances where real-time clinical attendance is not possible. If a clinical assessor cannot be contacted at the time the assessment is taking place, the assessor will complete the questions that do not require clinical judgement. All other clinical questions are noted and cannot be asked. In this instance, if the assessor is using the IAT in the Assessor Portal or the Aged Care Assessor App, it is advised the assessor selects 'no' to the declaration. The assessor can revisit the question/s once a clinical assessor is in attendance. As the assessor continues through the IAT, they will need to make note of the clinical questions prompted (see appendix D) and ensure that these questions are answered with a clinical assessor in attendance. The assessment will end once the assessor has completed the non-clinical questions in the IAT (noting the IAT itself will remain incomplete). The assessor will need to speak with a clinical assessor in their organisation about the assessment and the clinical questions. If it is appropriate for the clinical questions to be asked by a clinical assessor over the phone, arrangements will be made with the older person and relevant support people for this to take place. It is preferable the original, non-clinical assessor is also on the call. If the clinical components are completed over the phone by a clinical assessor, the assessment does not need to be reassigned to this assessor. It may be determined that the assessment should be reassigned to a clinical assessor to complete the assessment, either in person or over the phone. This may be required because: • multiple clinical questions are triggered in the IAT, • the needs of the older person are best assessed in person to ensure a high-quality assessment. Where an in-person assessment with a clinical assessor is required, a team leader will reassign the assessment to a clinical assessor.

If the clinical process is initiated the assessor must:

- ensure the older person understands that there are questions in the assessment tool that need to be asked with a clinically qualified assessor so that they can apply clinical knowledge and judgment to ensure that the older person's needs are assessed in full and with their safety and wellbeing in mind. This should occur before the clinical assessor is contacted.
- include the older person in the initial discussion when the clinical assessor is being briefed on the older person's situation. The older person and/or their support person should be given the opportunity to describe their circumstances if they feel comfortable to do so.
- ensure the camera is on at both ends so that older person can see the clinical assessor if the clinical assessor is called in on a video enabled device.
- ensure the call is on speaker phone so that the older person and clinical assessor can speak directly to one another, if the clinical assessor is called on a phone without video functionality.
- explain to the older person that a follow-up phone call will be necessary to complete their assessment, if real-time clinical attendance is not possible.

If a follow-up call is necessary:

- the original non-clinical assessor should be present on the phone call to ensure there is continuity of contact with the original assessor.
- it is important that the non-clinical assessor keeps the older person, their primary contact and/or support person up to date on when the follow up phone call will take place.

5.7.2. Tools and techniques for assessing an older person's needs

The table below details best practice tools and techniques for undertaking aged care needs assessments.

Table 21. Aged care needs assessment best practice tools and techniques

Use the Aged Care Assessment Quality Framework	• Use the four quality goals, personal, effective, connected and safe in your assessment practice.
Use a conversational approach when interacting with the older person	• Confirm with the older person that they are comfortable with digital devices being used during their assessment, ensuring that the older person understands why and how the information recorded is used during the assessment. • Use a conversational approach when asking questions, rather than simply running through the assessment questions and ticking boxes. Ensure your conversation is undertaken in a manner that is respectful, non-judgmental, and non-confrontational. • Know when and how to best use closed, open, direct, and indirect questioning. • Use motivational interviewing techniques such as expressing empathy and eliciting self-motivational statements. • Use active listening skills. • Make eye contact to help engage the older person in the assessment process, unless it is culturally inappropriate to do so. For example, some Aboriginal and Torres Strait Islander people may consider direct eye contacts disrespectful or uncomfortable, but others may be more comfortable with Western norms of communication. If using a computer at the older person's home, ensure you are not focused on just the computer. • Gauge the older person's level of engagement in the assessment. Look for signs of fatigue or discomfort and adjust approach accordingly. For Aboriginal and Torres Strait Islander clients • Observe the local cultures and customs when conducting the assessment. • Start with a social yarn to build rapport and trust. Share stories or other topics of common interest. • Take a whole-of-person approach to the discussion – understanding what motivates a person and contributes to their wellbeing – spiritual, emotional, and physical. • Explain to the older person and any support people present that if they feel uncomfortable during the assessment at any time, the assessment will be paused and rescheduled to ensure their wellbeing. Allow for

	multiple visits, if required, to build trust and develop a relationship between the assessor and the older person • Welcome the presence of the older person's family member or advocate to be part of the meetings • Take a less formal, yarning approach to aged care assessment.
Use appropriate language when speaking with the older person	• Use needs-focused language, explaining what could be short-term vs. long-term options to meet their needs. • Use language that is positive and not dismissive. If necessary, potentially sensitive topics (such as lack of service availability or older person fees) can be introduced at the appropriate place during the assessment process after the older person's areas of concern and goals have been identified, and when support options are being explored in the Support Plan stage. • Use language that focuses on the older person's strengths, abilities and what they want to achieve and how these could be further supported – a focus on independence. • Take the time to explain what will happen • Use informal and the local language where possible and avoid jargon • Adjust language as needed to ensure sensitivity towards End-of-Life Pathway participants (for example, focusing on more immediate needs rather than longer-term goals). • Reflect the conversation back to the older person to ensure you have understood what was said and agreed on.
Interpreters or support person	• where the older person prefers to communicate in a language other than English or has indicated in their record that a support person is required, an interpreter or support person must attend the assessment (either in-person or via phone).
Supporting people with dementia and other cognitive impairments	• Use simplified language where appropriate. • Repeat questions and information where needed • Be attuned to non-verbal signs that the person may need further information to help them understand. • Consider body language, including facial expressions and posture. • Consider the assessment environment, particularly background noise or activities competing for attention • Seek discrete responses to questions (e.g. 'Yes' or 'No,' or choices between two options) rather than multiple options. • Provide ample time for a person to respond to questions.

Using Validated Assessment Tools	Assessors may wish to use assessment tools not included in the Validated Assessment Tools within the IAT to enhance assessment and strengthen objective evidence for an assessment recommendation(s). This is at the discretion of the assessment organisation. Clinical assessors should use their clinical judgement to determine if it is appropriate to use other Validated Assessment Tools. If other assessment tools are used, the assessor should make a note of this in their assessment summary. The assessor should record assessment tool outcomes and recommendations based on these outcomes within the Assessment Summary. The assessor should also make sure that the older person and their support people understand the outcome of any assessment tools used.
Observing functional activities	Where possible, assessors must observe the older person's activities to gain insight beyond information that is conveyed just verbally by the older person, a registered supporter or anyone else who supports the older person. Therefore, collect information through additional means: • ask the older person to ***show you*** how tasks are completed in the home and ***observe*** the older person undertaking those tasks (this is an 'active' assessment) and • advise the older person ***what*** you have observed/seen during the task.

5.7.3. Aboriginal and Torres Strait Islander assessments

To support timely access to services, assessors are encouraged to use their professional judgement to determine when an assessment can be completed in one session or, be split over a few sessions without disadvantaging the client from receiving timely services.

By starting the assessment with a yarn, the assessor should be able to gauge whether it is appropriate to proceed with completing the assessment during the session.

Where an assessment cannot be finalised during the initial session and additional sittings are required, the assessors should complete the initial yarn and schedule a follow up assessment. The subsequent sessions should be conducted as soon as practicable, as service referrals cannot proceed until the assessment is completed and the Support Plan has been approved by the assessment delegate.

While the assessment remains open, the assessment organisation should maintain regular check ins with the client to ensure their circumstances have not changed. This ongoing engagement helps ensure the assessment remains accurate and responsive to the older person's needs.

Factors to consider in determining whether to complete the assessment on the first visit include:

- **Support from Elder Care Support worker**: Has an Elder Care Support worker facilitated the older person's entry into the aged care system, explained the assessment process, and help built trust in engaging with aged care?
- **Client Engagement and Readiness:** Are the client's body language and verbal cues non-responsive, suggesting they need more time to become familiar with the concept of aged care assessments?
- **Availability of Information:** Has sufficient information been collected from various sources to allow the assessment to be undertaken in one sitting?
- **Supportive Environment:** Are family and/or community members present and helping to create a safe and non-stressful environment for the assessment?

5.7.4. Aboriginal and Torres Strait Islander assessment organisations delivering home support assessments

Aboriginal and Torres Strait Islander assessment organisations participating in the pilot are expanding their expertise to deliver comprehensive assessments. If a non-clinical assessor triggers clinical questions within the IAT and the organisation does not yet have clinical assessors or full capability to provide comprehensive assessments including if the IAT Outcome generates a Support at Home Classification level, the following action must be taken to ensure continuity of care and uphold a client centred experience:

- Clearly explain next steps
- If the assessment is not finalised, and a cancellation is necessary, the assessor will only be able to refer the client for urgent aged care services through the alternative entry pathway (see Chapter 3 for further detail),
- To preserve valuable information, the assessor should print the information from the "client's assessment history" tab before cancellation and upload the document to the client's record.
- Facilitate a supported referral by contacting another organisation with capacity for comprehensive assessment.
- Provide information on interim supports and assist with connections where possible.
- Maintain engagement with client and their support network and, where appropriate, include an Elder Care Support worker, to ensure continuity of care throughout the process.

5.7.5. Recording assessment information

Assessors should make sure all important assessment information is recorded before leaving the assessment. The assessment information in the IAT should be transparent, objective, accurate, complete and in plain language.

Before an assessment is finalised, assessors should perform a quality check on the assessment information, expanding on information and assessment evidence where required. Accurate recording of assessment information prevents unnecessary follow-up

queries and makes it more easily readable and usable for people who need to access it in the future. Once the IAT is finalised, it will become read-only and cannot be edited.

The accurate recording of assessment information (see the Aged Care Assessment Quality Framework):

- lays the foundation for creating the Support Plan for the older person and is reflective of what the older person said, was observed doing, and/or reported by carers/support persons
- minimises duplication between the assessment and Support Plan
- provides sufficient evidence for assessment delegate decision
- is required for audit purposes
- helps to inform an older person's provision of care and highlights important information or risks about the older person's situation that needs to be managed by the care provider or other parties
- puts the older person at the centre of the Support Plan

Depending on the risk and issues highlighted in the assessment, the assessor must decide where to record the information in the older person's record, e.g., in the IAT, the Support Plan, in Notes, as attachments or as sensitive notes or sensitive attachments.

Assessment information and evidence should include all relevant documentation that supports the recommendations and decisions made throughout the assessment process. All documents must be in PDF format and finalised in the My Aged Care Assessor Portal. The department is unable to access documents submitted to the Assessor Portal unless they have been finalised. The assessment documentation must include:

- Consent
- IAT and Validated Assessment Tools (VATs)
- Additional Evidence
- Support Plan and Recommendations
- Notice of Decision letter
- Referral Information

The assessment should contain comprehensive information to support the justification of the assessor's recommendation for funded aged care approvals.

Recording sensitive information

If the older person shares (or the assessor is in receipt of) sensitive information, with the older person's consent this can be recorded by adding a sensitive note and/or a sensitive attachment on the older person's record. This information will not display to providers or to older persons viewing their information through the My Aged Care Online Account and will be visible only to assessors and contact centre/ACSO staff.

Sensitive notes should be used to record information that is of importance. This may include information about:

- financial issues
- safety concerns
- health issues
- legal situations
- past experiences of trauma

For example, a sensitive note could be used to record a personal safety issue such as conflict between family members causing the older person to be anxious.

> Note:
>
> Assessors must follow their reporting obligation specified in relevant legislation and protocols in their state or territory where they identify an older person is at risk of elder abuse.

Sensitive notes and attachments are not visible through the My Aged Care Service and Support portal. Instead, a message will display on the older person's record stating "the older person has a sensitive note/attachment on their record."

Given the assessor may be best placed to discuss the sensitive issues with the provider/s, the provider could contact the assessment organisation for enquiries on notes and/or attachments. The provider may also contact the assessor directly if they have a question concerning sensitive attachments. Sensitive information may be disclosed to the provider if it is relevant to their particular service. For example, where it is recorded that an older person has a sensitive health issue, an assessor may be contacted by a garden maintenance provider and the assessor may consider it inappropriate to disclose the information; whereas if the assessor is contacted by a personal care provider, the assessor may have a duty of care to disclose the information as it has implications for the service being delivered.

Where an existing older person currently receiving services has received a reassessment, and has disclosed new information that is categorised and recorded as a 'sensitive' note (that may impact the safety and welfare of the older person, staff or other older people), the assessor should contact the provider/s to make them aware of the sensitive information and enable them to make a risk-determination of how best to support the older person for the safe delivery of services (see section 12.12.4 Older people who are in prison).

Sensitive user flag

The My Aged Care system also enables an older person or registered supporter to be flagged as a 'sensitive user' if the older person or registered supporter requests to limit access to their information, AND the older person or registered supporter:

- works for My Aged Care or the department
- has a conflict of interest with My Aged Care staff, or
- has provided reasonable justification to support that their identity and contact information is to be protected.

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

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



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

5.7.6. Urgent service provision in the IAT

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

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

- is considered at urgent and immediate risk in terms of their personal safety; and/or
- is at immediate risk of admission into residential care; and/or
- is unable to be safely discharged from hospital without timely access to in-home care; and/or
- has a carer, and the carer arrangements are unsustainable, or the carer is at crisis point.

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

Table 22. Urgent service provision guide

	Carer arrangements are unsustainable	Urgent and immediate risk to personal safety	Immediate risk of admission into residential care	Requires home care support to be discharged from hospital
Criteria for determining urgency	Indicators that a carer arrangement is unsustainable: • Carer in crisis • Carer may have a dual caring role. • Carer's employment is being jeopardised by their caring duties • Carer may be returning to full time employment. • The level of care required by the older person is increasingly more complex and the primary carer is unable to provide the level of assistance required. • Recent changes in the older people' family, cultural, housing or	Some indicators of a person being at urgent and immediate risk with respect to their personal safety may include, but are not limited to: • Neglect of basic needs i.e., unable to access or prepare food resulting in malnutrition, weight loss or dehydration • Inadequate personal hygiene such as severe neglect of personal care leading to serious hygiene issues, infections or injuries. • Repeated hospital admissions due to frequent falls with sustained injuries. • Failure to administer necessary medications/treatments and/or attend medical appointments. For example, medication mishaps with potential for adverse outcomes.	There is an immediate risk of the older person entering Residential Care due to: • carer in crisis and/or inability of carer to offer required support; or • Lack of access to services to meet the older persons' needs and fairly mitigate immediacy of risk to personal safety • If the older person had access to these services (as	The older person cannot be safely discharged from hospital without significant risk, where: • A lack of access to services in the home would create significant risk of re-admission to hospital; and • If the older person had access to these services (as soon as possible following hospital discharge), their care needs could be managed at home. Note: As there will still be a wait time for the older

Carer arrangements are unsustainable	Urgent and immediate risk to personal safety	Immediate risk of admission into residential care	Requires home care support to be discharged from hospital
social situation resulting in trauma, or feeling unsafe (including culturally unsafe) The carer in crisis is no longer able to provide care due to: • A change in the carer's personal circumstance i.e. death/significant decline in carers own health status • An inability to sustain their caring role due to a lack of assistance being received i.e. the older person has significant needs and no (or minimal) support is being provided. **NOTE**: Carer in crisis is different to caregiver stress. Caregiver stress is a condition of exhaustion, anger, or guilt that results from unrelieved	• Severe cognitive impairments with behavioural and psychological symptoms impacting client safety (e.g. wandering) • Person is unable to safely navigate their home and community due to insufficient aids, equipment and/or home modifications. • Recent changes in the older person's family, cultural, housing or social situation resulting in trauma, or feeling unsafe (including culturally unsafe)	soon as possible), they could be managed at home.	person's Support at Home funding to become available, a comprehensive assessment should be performed as soon as possible to support continuity of care and to not delay discharge.

	Carer arrangements are unsustainable	Urgent and immediate risk to personal safety	Immediate risk of admission into residential care	Requires home care support to be discharged from hospital
	caring for a chronically ill dependent. The stress can vary depending on the individual and generally does not prohibit the carer from providing care. Caregiver stress can be reduced by accessing respite care.			

Concerns, goals and recommendations

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

After recording observations under all relevant domains and categories in the IAT and prior to finalising the IAT (noting that once the IAT is finalised, answers in the IAT become read-only) the assessor supports the older person to identify the goals they would like to achieve to help address their areas of concern.

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

Assessors must:

- Draft and include at least one Concern and Goal linked to any recommended services. If no services are recommended or no change to services is required, a Concern and Goal does not need to be included.
- Draft Concerns and Goals that are clear, actionable, realistic and written from the older person's perspective (e.g., I find showering to be painful (concern). I would like to learn ways to have a shower without pain and reduce my pain rating from moderate (6/10) to mild to (3/10) (goal)).
- The older person's Concerns, Goals and recommendations will become clear as the assessor conducts the assessment and records their observations within the IAT. The assessor must ensure that the older person's Concerns and Goals reflect their needs as detailed in the IAT (e.g., Physical and Medical domains of the IAT provide details of the Mr Arnolds functional limitations with showering and the pain he is experiencing).
- Consider whether the older person will benefit from a short-term reablement intervention to maximise their independence, choice and quality of life, and the older person's capability, motivation, and strengths to contribute to their goals. Reablement can be provided by the assessor or by CHSP providers, with assessor review to determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.
- Consider whether the goals identified suggest suitability for Restorative Care Pathway (RCP) such as improving function, learning, reablement, or other goals which support delaying the need for higher level or ongoing services. This consideration should include whether a person has the motivation and capacity to actively participate in RCP including attending frequent allied health interventions (over more passive interventions). The need for a multi-disciplinary allied health and/or nursing approach to care must also be required before recommending RCP. Consideration of long-term needs should also be given before approving RCP as it will impact their position on the Support at Home prioritisation system.
- Consider the overall volume of RCP recommendations being made and any guidance or operational advice regarding system pressures or delays in accessing RCP. If timely access to RCP may be uncertain, assessors may wish to discuss alternative supports with the older person.

- Consider, throughout the assessment, whether the older person will benefit from assistive technology and home modifications funding to support functional needs and safety at home in areas such as:
    - managing body functions
    - self-care
    - mobility
    - domestic life
    - communication and information management

5.7.7. Classification algorithm

About the classification algorithm

The ongoing home support classification algorithm (classification algorithm) is a set of business rules used to assign individuals an ongoing home support classification level. The outcome of the algorithm that is known as the IAT Outcome in the assessment workflow.

The classification algorithm was introduced on the commencement of the Support at Home program and *Aged Care Act 2024.* It is designed to place people with similar clinical care needs in a classification level for ongoing home support, which confers a funding amount. This intends to:

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

The classification algorithm was carefully developed over time and built on data from over 22,000 assessments conducted in 2023 through the IAT live trial. Before it was implemented, the algorithm was refined using more than 200,000 assessments completed in 2024-25. This process was undertaken to ensure it would achieve the best outcomes for older people, deliver on the policy intent of the Support at Home program and support the responsible use of taxpayer funds.

How the classification algorithm works

The classification algorithm uses data that an assessor enters into the IAT during an assessment across a number of domains in the tool. The algorithm uses this data to evaluate an older person's clinical characteristics and assigns a classification level (or funding level) for ongoing home support (i.e., CHSP or Support at Home). The classification algorithm ingests the information entered by the assessor about an older person's functional ability, the extent to which their needs are being met, and other compounding factors that introduce additional complexity for an older person compared to others with similar functional ability and needs met.

For a given set of clinical characteristics, the classification algorithm will always generate the same classification level. The rules or criteria that must be met for each ongoing home support classification level are defined in section 81-10 of the *Aged Care Rules 2025* (the Rules). The Rules are prescriptive and do not allow for an ongoing home support classification to be approved that is different to the rules it describes and which the algorithm relies on. Therefore, overriding the classification algorithm outcome to a different ongoing

home support classification level (e.g., CHSP to SaH class 1-8; ineligible for CHSP/SaH to CHSP or SaH class 1-8; SaH class 1-8 to a different SaH class 1-8) is unlawful.

The accuracy of the IAT Outcome relies on information that has been entered into the IAT during the assessment. Assessors continue to play a critical role in achieving high quality assessment outcomes by using their strong communication and interpersonal skills to complete the IAT during the assessment, and their clinical judgement when undertaking comprehensive assessments.

Accepting the IAT Outcome

If an assessor intends to recommend ongoing home support for an older person through Support at Home or CHSP, the system generated IAT Outcome must be accepted by the assessor. For example, where the IAT Outcome recommends an ongoing SaH class 5, the assessor will accept this IAT Outcome to recommend ongoing SaH class 5.

Note: Under the *Aged Care Rules 2025,* if the individual is a Disability Support for Older Australians (DSOA) Program client and they receive an IAT Outcome recommending an ongoing SaH class, the assessor is permitted to override the algorithm and select the CHSP classification, if that is preferred by the individual

Accepting a SaH package outcome will result in a DSOA client having their DSOA funding capped on an ongoing basis. Should a DSOA client access a SaH package, this will result in the DSOA client being exited from the DSOA Program. Assessors should ensure that DSOA clients considering accessing a SaH package are fully informed of the impact of the assessment on their DSOA funding *before* finalising the client's assessment.

If the IAT Outcome results in 'ineligible for CHSP/SaH,' the person is not eligible to receive CHSP or ongoing SaH. An assessor must not override the IAT Outcome to recommend an ongoing home support classification level. If by considering the eligibility criteria in the *Aged Care Act 2024* for residential care, the assessor wants to recommend residential care, it is appropriate to accept the ineligibility outcome and recommend residential care.

Important:

To support the IAT Outcome recommending a level of care which appropriately addresses an individual's care needs, assessors should ensure all inputs into the IAT are accurate before it is finalised. From 29 June 2026, the IAT amendment process will allow Assessment Delegates to return a finalised IAT to assessors to correct errors and resubmit it. This process can only be used once per assessment.

Overriding the IAT Outcome

Important:

There is functionality in the assessor workflow that allows for actions that must not be taken by assessors as these actions do not align with the *Aged Care Rules 2025 (the Rules),* deeming them unlawful. This includes:

1. The IAT Outcome must **not be overridden** to recommend a different ongoing home support classification (e.g., Ineligible for CHSP/SaH to CHSP or SaH 1-8; CHSP to SaH 1-8; SaH 1-8 to CHSP; SaH 5 to SaH 6). In line with section 81-10 of the Rules, the criteria for each classification are prescriptive and do not allow for the recommendation of an ongoing classification different to the IAT Outcome.

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

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

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

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

Note: In order to recommend residential care (permanent or short-term) without ongoing in-home services, assessors will need to override the IAT Outcome of CHSP or Support at Home to ‘ineligible for ongoing SaH/CHSP.’ Assessors can then recommend these care types in the support plan. Assessors may also approve an ongoing home support classification alongside residential care and select ‘not seeking services’ to avoid a reassessment being required for older person if they choose to return home.

An older person can be recommended and approved for CHSP or Support at Home services at the same time as TCP, provided the IAT Outcome generates an ongoing home support outcome. For example, Support at Home services can only be recommended if the IAT Outcome generates a SaH 1-8 classification level and CHSP services may also be recommended in the interim. If the IAT Outcome results in a CHSP classification, only CHSP services can be recommended.

If it is not appropriate to recommend ongoing home support services at the same time as TCP for people new to the aged care system, the IAT Outcome can be overridden to ‘ineligible for CHSP/SaH’ and then the transition care option can be chosen under ‘Add a Care type for Delegate Decision’ button. The system will not allow CHSP services to be recommended concurrently with TCP if the IAT Outcome has been overridden with ‘Ineligible for CHSP/SaH.’ The client may need a support plan review or reassessment at the end of their transition care period to establish their long-term care requirements.

For transitioned HCP, SaH clients and CHSP clients who are assessed for TCP, the IAT Outcome will need to be accepted, and Transition Care – After Hospital Care added as a care type. These services can continue to be accessed while accessing TCP, as long as the services are not duplicative. See Chapter 6 for further information.

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

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

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

- I have put the information you/<older person's name> have/has given me during your/their assessment into the assessment tool and the system has generated an outcome for your/their <eligibility for CHSP/level of funding for Support of Home> OR <ineligibility for ongoing home support services>.
- The system uses a set of rules which rely on information that you/they have told me during your/their assessment which include:
    - Your/their functional ability to undertake daily tasks e.g. walking, eating, bathing, toileting, managing their finances, cooking, and shopping, and
    - the extent to which your/their needs are currently being met, and
    - other factors that may introduce additional complexity for you/them such as sensory concerns, medical conditions and co-morbidities (i.e., the simultaneous presence of two or more diseases or medical conditions), carer availability, mental health, continence, and vision impairment.
- Your/their level of funding for ongoing home care services has been determined using this set of rules.
- This helps to ensure consistency in how funding is assigned and means that your/their funding level will be the same as other people who have similar needs and clinical characteristics.
- I have included services in your support plan that will help to meet your goals and needs. Once approved and your funding is assigned to you, you can work with a provider to determine the services you will receive and how often within your funding level.

Note: While these tips aim to provide assessors with clear and accurate advice about how to describe IAT Outcomes for ongoing home support when talking to older people and their supporters, we encourage all Assessment Organisations to work with their assessors on scripts and strategies they can use to support them to have these conversations using a person centred, educative and positive approach.

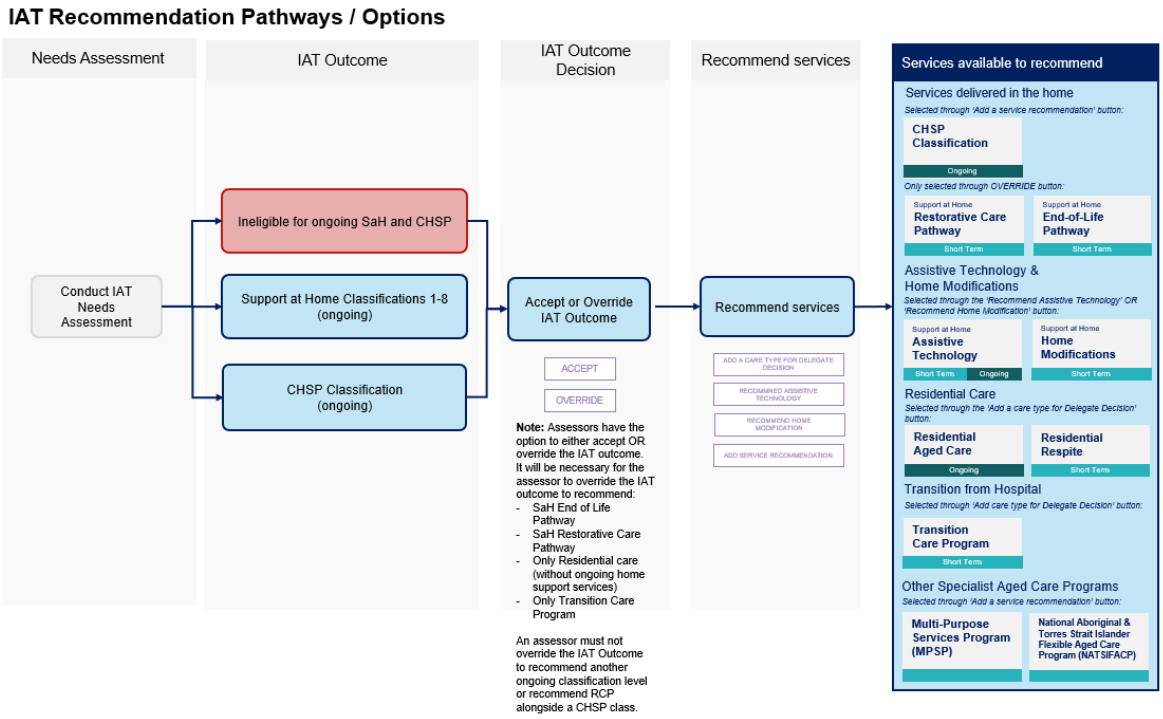


Figure 4 - IAT recommendation pathways and outcomes

5.8. Converting a home support assessment to a comprehensive assessment

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

> Note: Enrolled Nurses (EN) who hold the clinical assessor role may provide supervision to non-clinical assessors if a home support assessment is converted to recommend Support at Home and no clinical questions have been triggered in the IAT. ENs must ensure that they continue to act within their scope of practice.

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

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

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

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

The supervision required to convert a home support assessment to a comprehensive assessment is not the same as the clinical attendance process outlined in Section 5.7. Rather, it is a conversation between assessors to ensure the support plan reflects the needs of the older person and the appropriate care recommendations are included for delegate approval. There is no requirement for the assessment to be undertaken again by the clinical assessor.

5.9. Developing a high-quality support plan

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

The Support Plan sections include:

- Assessment summary
- Concerns and goals
- Service recommendations

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

> Note:
>
> The Support Plan functionality in the system accommodates the Support at Home classes and associated service recommendations and AT-HM scheme.
>
> Once finalised, the Support Plan is sent to the older person, and their registered supporter/s and/or appointed decision maker/s as applicable (via post and/or email), as a record of the assessment, accompanied by a Notice of Decision letter. Registered providers also use the support plan to inform the individual's care plan; therefore, accuracy and clarity is essential.
>
> Referral codes are included in the Support Plan for the majority of services approved however there are several nuances about where they will appear depending on the program or pathway. For further detail on how referral codes will be communicated to clients and providers, see section 9.4 Referral and support for service access

5.9.1. Assessment summary

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

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

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

The assessment summary must:

- Be written in a succinct manner (using the ISBAR approach), focusing on relevant/essential information.
- Be presented in a structured way that makes the information easy to interpret.
- Be understandable to anyone without prior knowledge. Limit spelling and grammatical errors and avoid acronyms, abbreviations, jargon, and unnecessary headings.
- Provide a holistic and complete summary of the older person's assessment at that time.
- Be relevant. Only include information that is relevant to the older person's current situation. This may mean updating previous information.

Assessors must also:

- Use the 'pre-populate' function in the Assessor Portal to enable the ISBAR template to tailor the pre-populated assessment information in consultation with the older person. Ensure the Assessment summary is not limited to pre-populated information but includes a holistic, comprehensive view of the older person as per information collected from the assessment.
- Avoid simple dot point form. Information should be re-written in a sentence format that is succinct, objective, supports the client's needs, readable to the older person and justifies funding for My Aged Care services. See template in the Table 23 below.
- Review and edit information populated from the assessment – such as functional needs, health conditions, support considerations, and complexity indicators. For a SPR or reassessment, the assessor (in updating previous information) may need to remove content that is no longer current to remain within the 5000 character system limit. All past versions of the Support Plan are retained as a record of any deleted content. Each Support Plan must reflect the older person's current needs and circumstances. Historical content needs to be clearly identified or removed to ensure clarity of current needs.
- If clinical attendance occurred during the assessment process, the assessor must make a note of this in the Support Plan.
- Enrolled Nurses (EN) who complete a comprehensive assessment must include a statement in the support plan that the assessment has been conducted under direct or indirect RN supervision within the same organisation

> Note
>
> Learner assessors must be supervised by an experienced certified assessor through their learning pathway. The Support Plans developed by learners, before their appraisal activity 2 is marked complete, must include a statement that the assessment was conducted under supervision and include the supervisor's name.

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

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

Table 23. Assessment summary template using the ISBAR approach

ISBAR topic	Assessment information
Introduction	• Older person's name and age • Reason for assessment, including referral details (who made the referral and why, if appropriate) • Assessment details – type (home support or comprehensive), date, location, mode, attendees, assessor name • Whether the assessor is an EN requiring direct/indirect supervision from an RN.
Situation	• Key health conditions that impact functional limitations and need for an aged care assessment • Medical issues (clinical assessors to include diagnosis status) *
Background	• Living arrangements* • Diversity considerations supporting the Statement of Rights and Principles • Current social situation and social history* • Current support ○ Carer profile (including details of Power of Attorney in place) ○ Other informal supports* ○ Current and previous services including aged care, mental health, disability, palliative care
Assessment	• Assessment observations (include carer involvement/carer strain) under the relevant domains: Function • Medical and medications

ISBAR topic	Assessment information
	• Physical and personal health and frailty • Social • Cognition • Behaviour • Psychological • Home and personal safety • Financial or legal • Support considerations • Whether clinical attendance was sought by a non-clinical assessor • Reference the use of any validated assessment tool (including those conducted through use of clinical attendance), the outcome of the tool and how that outcome was incorporated into the assessment.
Recommendations	• Previous approvals • Current recommendations* ○ Reason for the recommendation (the older person benefit from X) ○ Comments to support recommended CHSP services for a temporary period ○ Comments relating to the urgency of service ○ Who is to action the recommendation – older person, assessor ○ Recommendations associated with the carer and/or affected support person/s ○ Recommendations must be justified by a clear link to assessment outcomes and support the older person's goals and concerns. • Referrals* ○ Status of referral (e.g., referral made with consent, older person declined referral) ○ Who is responsible for contacting services ○ Time-limited/end date or review date, or a rationale for ongoing services. • Contact details (if not older person) * • Who has been sent a copy of the Support Plan, including whether it has been linked to the older person's My Health Record*

*Indicates items that are not pre-populated

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

Introduction section: Sets the scene for the assessment. This section should include the client's name and age, the type of assessment being conducted, the reason for assessment, support persons present such as carers/registered support persons/translation services, the date of when the assessment took place, whether the assessment was conducted face-to-face or via telehealth or telephone, the name of the assessor including supervising assessors (including registered nurses if assessor is an enrolled nurse).

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

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

Assessment section: Include all relevant sections of the assessment and highlight any complexity indicators. Record detailed observations against the domains and use language such as 'the older person experiences X and has difficulty with Y, they would benefit from Z.' It should include all validated assessment tools and its scores that were used in the 'assessment' section along with an explanation of what the score indicates. This should include reference to completion of the DEMMI modified tool if respite is recommended – see section 6.10.1Recommending residential respite care for more information. The assessor should exercise clinical judgement on whether specific scores should be excluded (e.g. sensitivity content for the older person)

Recommendation section: Include all new recommendations/continuation of existing approvals, status of service referrals, time limited/ongoing/interim supports, who is responsible for actioning next steps, older persons' contact details and whether clinical attendance was required. Ensure that recommendations can be justified clearly through the Assessment Summary ISBAR format. Ensure that the information provided here can be linked to the older persons' service recommendations and approvals under the Goals and Concerns. It is best practice to revisit the recommendations section of the Assessment Summary following recording the older person's Concerns and Goals and prior to finalising the IAT.

5.10. Wellness and reablement approach

Wellness and reablement are person-centred, holistic approaches to service delivery. They build on people's strengths, capacity and goals to promote greater independence and autonomy. Wellness and reablement approaches are based on the premise that, even for individuals who experience frailty, older people want to improve their physical, social and emotional wellbeing, and remain living at home, connected to their community.

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

5.10.1. Delivering reablement

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

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

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

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

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

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

with the aim to wrap up and cease the services when the older person has met their goal or specific outcome.

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

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

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

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

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

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

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

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

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

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

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

The following Steps/Activities are required for facilitating reablement:

- Consider if the older person would benefit from short-term reablement support, particularly if the older person has experienced some functional loss and expresses the desire to improve independence and/or regain confidence and capacity to resume activities, including connecting with their community.
- Consider assistive technology or home modifications for reablement support. Support at Home participants for example, if the older person would benefit from a shower chair under the AT-HM scheme or for CHSP clients, an equipment and products referral to assist them with showering and preserve their dignity, instead of having a support worker to attend and shower them.
- Where reablement is to be provided by one or more CHSP providers, recommend a period of reablement on the older person’s Support Plan. This function allows assessors to identify older people who would benefit from reablement and allow assessors to make changes to the older person’s Support Plan during the reablement period. Users accessing the older person’s record (such as older people and service providers) will be informed that the older person is undergoing a period of linking support and/or reablement.
- Focus on elements of functional tasks that an older person can complete, and discuss what specific assistance they would benefit from in order to complete the task by themselves (to maintain and continue the independence to live at home)
- Discuss strategies an older person can employ to more easily manage day-to-day tasks (e.g., transport planning to meet goals around the use of public transport to maintain usual activities)
- It is important to ask what goals the older person wants to achieve. This can be as simple as making a cup of tea without help, or to understand their bus timetable. A goal could be walking to the local bus stop to go shopping, or to get to regular senior’s events. Even small goals go a long way towards building self-confidence and regaining (or maintaining) skills to get back to doing things for oneself, to be more independent;
- When looking at what goals the older person could achieve, start by asking what a good day looks like for them? Then work out with the older person what goals they need to achieve to have more of those good days.
- Consider the older person’s need for a mix of short-term, episodic, or ongoing services across CHSP service types (e.g., short-term personal care, episodic allied health, ongoing transport). Review this approach regularly to ensure the intensity of services matches the older person’s needs.

- Maintain regular contact with the older person and providers and during the period of reablement.
- In consultation, determine when the reablement period should be finalised and what ongoing support (if any) may be required for the older person.
- Develop local knowledge of reablement-type services in the region. Discuss with local providers their capacity and willingness to take on short-term older people as part of a reablement episode.
- An expanded in-depth description of Supporting Independence: Reablement including older person scenarios is at APPENDIX E – Wellness and reablement.



Department of Health, Disability and Ageing website:

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

5.10.2. Linking supports

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

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

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

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

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

Elder Care Support workers can be key partners in delivering culturally safe, trauma-aware, and healing informed assessments. With a client's consent, Elder Care Support workers could attend an assessment to provide trusted experience for the older person. The assessor should work closely with Elder Care Support staff to facilitate a warm handover.

This collaboration ensures continuity of care and supports a culturally safe and trusted transition for the older person into aged care services.

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



Department of Health, Disability and Ageing website:

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

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

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

Delivering linking support/care coordination to vulnerable older people

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

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

Identifying a vulnerable person for linking support

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

The older person:

- is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, wellbeing, and ability to remain living in the community,
- is at risk of, experiencing (or suspected to be experiencing) abuse,
- has emotional or mental health issues which significantly limits self-care capability, requires intensive supervision and/or frequent changes to support,

- is experiencing financial disadvantage or other barriers that threaten their access to services essential to their support,
- has experienced adverse effects of institutionalisation and/or systems abuse (e.g., spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and wellbeing,
- is exposed to risks due to drug and/or alcohol related issues and is likely to cause harm to themselves or others,
- is exposed to risks or is self-neglecting of personal care and/or safety and is likely to cause harm to themselves or others,
- has a cognitive impairment (e.g. memory problem or confusion) that significantly limits self-care capacity, requires intensive supervision and/or frequent changes to support.

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

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

a) from a culturally and linguistically diverse background
b) an Aboriginal and/or Torres Strait Islander person
c) Living in a rural, remote or very remote areas
d) Financially or socially disadvantaged
e) A Veteran
f) Homeless
g) at risk of experiencing homelessness
h) a lesbian, gay, bisexual, trans/transgender or intersex person
i) Parents and children who are separated by forced adoption or removal
j) A socially isolated individual
k) Other (assessor to specify)'

Further information on identifying and supporting vulnerable cohorts is included in Chapter 12: Supporting diverse experiences and needs.

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

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

(b) whether urgent intervention is required and

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

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

Linking support and short-term case management activities

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

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

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

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

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

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

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

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

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

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

It is expected that assessors will work closely with vulnerable older people on a low income, or who are living with hoarding behaviour or in a squalid environment and at risk of homelessness, or who are unable to receive the aged care services they need. Where there

is no coverage for hoarding and squalor assistance, the eligible older person can be referred to CHSP services such as social work and other services targeted at avoiding or reducing the impact of hoarding and squalor situations (see section 6.5.3 Hoarding & squalor assistance).

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

My Aged Care system function – linking support

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

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

5.11. Vulnerable older people relating to aged care services

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

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

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

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



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

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

The assessor must carry out the following steps and activities:

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

5.12. Recommending aged care services

Note: Providers will not be able to deliver or claim for any services for an individual that are not approved in the support plan (even if there is an immediate need).

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

If ongoing Support at Home, Restorative Care Pathway or End-of-life Pathway, are recommended assessors will be taken directly to the 'Add Home Support services' page. On this page specific services are grouped by service type. These service types relate to the services in the *Aged Care Rules 2025*.

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

Important:

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

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

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

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

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

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

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

5.12.1. Making service recommendations

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

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

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

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

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

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

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

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

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

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

Important: If a person can access some services from an MPSP or NATISFACP provider, you must add an MPSP or NATISFACP service recommendation. See Chapter 6 for more information.

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

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

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

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

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

- For clients seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'seeking services.' This ensures that the older person is placed on the appropriate priority system(s).
- For clients not seeking these services through the Support at Home program, the assessor should set the relevant service seeking preference to 'not seeking services.'

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

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

An older person can change their service seeking preference by:

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

5.13. Review of Support Plan

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

A review date of no longer than 12 months should be set for older Aboriginal and Torres Strait Islander people to ensure the services still meet their needs.

5.13.1. Scheduling a support plan review for Aboriginal and Torres Strait Islander assessment organisations

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

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

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

5.14. Assessment wrap-up

At the end of the assessment, an assessor should inform the older person of the next steps so they have a realistic expectation of what will occur following the assessment. This will

help the older person to feel more assured and increase their satisfaction in the overall assessment experience. There are a variety of resources an assessor might leave with an older person at the conclusion of an assessment that are also available in many languages other than English (see section 13.6 Aged care resources for older people).

An assessor must:

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

5.14.1. Aboriginal and Torres Strait Islander Assessment Organisations assessment wrap-up

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

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

Follow up may include, but not limited to:

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



Resources | My Aged Care

5.14.2. Providing an assessment report for approval

Once the assessor has finalised the assessment, they must submit it for approval by an assessment delegate.

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

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

For older Aboriginal and Torres Strait Islander people, an assessment delegate only required to approve services at the service group level. This means the clients are automatically approved for all the service types and individual services within any service group they are approved for.

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

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

6. Chapter 6: Aged care programs

What you'll find in this chapter

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

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

6.1. Support at Home - ongoing classifications 1-8

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

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

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

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

Table 24. Approximate budgets for Support at Home classifications

The budget and annual amounts below are indicative, as indexation will occur on 1 July and 1 August 2026. For the latest budget information, please go to: Schedules of Subsidies and Supplements for Aged Care | Australian Government Department of Health, Disability and Ageing

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

Classification	Quarterly Budget	Annual Amount
On-going		
Home modifications Short-term (12 months)	Low ($500), medium ($2,000) and high ($15,000) funding tiers based on assessed need. Providers may apply for a funding tier time extension of an additional 12 months for HM high tier (24 months in total).	

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

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

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

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

Support at Home funding and finding a provider

Participants will receive a letter notifying them when funding (including interim funding) becomes available and is allocated. Participants have 56 calendar days from the date their funding was allocated to find a provider and enter a service agreement. They can contact My Aged Care to request a 28-day extension if required, giving them a total of 84 calendar days to enter a service agreement.

A participant's Support at Home funding will be withdrawn if they have not entered a service agreement within 56 calendar days (or 84 days with an extension). This means funding for their classification is no longer available and providers cannot provide government-funded services.

If the participant later decides they want to receive Support at Home services, they need to re-join the Support at Home Priority System by contacting My Aged Care. People who re-join the Support at Home Priority System will have their date of entry recorded as the date they were originally approved for Support at Home. Refer to Page 54 of the Support at Home program manual for more information.



Support at Home Program Manual

Note: An Assessor's role in budget planning and contributions

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

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

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

6.1.1. The Support at Home Priority System

An older person approved for Support at Home classifications 1 to 8 will enter the Support at Home Priority System in one of its four priority categories:

- Urgent
- High
- Medium
- Standard

An older person's priority category is determined using a prioritisation algorithm. The prioritisation algorithm uses a standardised set of seven criteria from the IAT and the client's record to place an older person in one of the four priority categories. The amount of time the older person waits to receive their funding will depend on the priority category they are given. The priority category will be displayed under 'Approvals for a Client' in the Assessor Portal.

The system will automatically recalculate an older person's priority category (if required) when changes are made to the following fields in their client profile:

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

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

6.2. Support at Home - Restorative Care Pathway

The Restorative Care Pathway (RCP) is designed to provide early intervention support to older people by:

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

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

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

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

> Important:
>
> An approval for RCP is equal to 1 unit of RCP funding (approximately $6,000). RCP units are capped to 20,000 units of funding annually (managed as 5,000 units of funding per quarter) across Australia.
>
> System-based visibility of RCP caps is not available.
>
> Weekly reports of allocations are generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.
>
> Assessors and Assessment Delegates should remain aware of any communication from the Department's Assessment Delivery Section regarding RCP units.

6.2.1. Assessing for the Restorative Care Pathway

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

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

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

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

- The person is assessed as experiencing functional decline that is likely to be reversed through frequent, multidisciplinary allied health and/or nursing interventions over a short period of time
- The person has goals which align with restorative care outcomes (improve function, want to be independent, rely less on others' help, regain previous levels of function, etc)
- The person demonstrates motivation through willingness and capacity to engage and actively participate in short-term clinical interventions to increase independence (for example, willing to attend frequent allied health appointments, engage in exercise and/or nutrition classes, learn how to apply techniques to regain independence, increase health literacy and education, etc)
- The person has received an ongoing SaH classification through the IAT Outcome (more information is included under section 6.2.3)
- The person is not receiving or, eligible for, the Transition Care Program
- The person is residing in a home or community setting
- The person is not in hospital at the time of assessment
- The person is not in permanent residential care The person is not eligible for, or has recently received, the End-of-Life Pathway
- The person has not been approved for more than two units of RCP funding in any 12-month period and/or at least 90 days have passed from the end of the 16 weeks period associated with the original episode.

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

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

Individuals who are residing in hospital and require support may instead be eligible for the Transition Care Program (TCP). Once a person has returned to a home or community setting and meets the relevant eligibility requirements, they may then be considered for RCP.

Case Study: Omar, age 66

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

Omar still has quite good mobility but needs some help building up his balance and strength to restore his confidence.

Omar has the support of Barbara and family who are keen to help him stay independent .

Omar initially had some concerns about undertaking the RCP but after discussion with the assessor, he is willing to try it as he would like to remain independent at home.

Omar's restorative care provides:

Biweekly strength classes which start as individual classes at Omar's home with an exercise physiologist but, as his confidence increases, transitions into group exercise classes at the allied health centre. This also provides opportunity for Omar to connect with others while supporting increases in physical and mental function.

Nutritionist support which provides insight and education into nutritional requirements to support his increased activity and support good health (plus meeting any cultural food requirements).

Two podiatrist appointments to assess for issues with his feet which are impacting his balance.

A restorative care partner who works with him on his goals and continues to support Omar, checking in periodically, monitoring his progress and continuing to discuss how problems achieving his goals can be resolved to help restore his confidence with the multidisciplinary team (MDT).

Outcomes

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

Case study: John, age 55

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

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

Delivery

John's restorative care provides:

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

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

Outcomes

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

6.2.2. Expectation setting

Expectation setting is an important part of ensuring restorative care is successful and helps ensure people receive the care they need. Assessors should ensure the roles, responsibilities and objectives of RCP are fully explained during the assessment (including in comparison to ongoing care). This should happen before the RCP is recommended to ensure the older person fully understands the support that will be available to them and their role. Older people who do not have the capacity or the willingness to engage with the RCP should not be recommended and approved for it.

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

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

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

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

- If, through a reassessment, the IAT Outcome is a higher ongoing classification, assessors will only be able to select the higher ongoing classification OR the RCP.

    - If the RCP is selected, the person will remain on their current ongoing classification (rather than the higher classification recommended).

- Assessors should consider if the older person's current provider delivers the RCP.

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

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

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

6.2.3. Recommending Restorative Care Pathway in the assessor portal

Upon finalisation of the IAT, if the IAT Outcome recommends an ongoing Support at Home classification, this can be overridden to change the IAT Outcome to the RCP by clicking the

override button. By overriding to the RCP, assessors will be navigated to the '*Add Home Support Services*' page to add services.

Assessors may also be prompted that the participant may be eligible for RCP based on the older person's goals, which appears upon finalising the IAT. The assessor will have the option to accept or reject this suggestion.

Upon overriding the IAT Outcome to RCP, or by accepting the prompt, the Assistive Technology Medium Tier and Home Modifications Medium tier will automatically be added to the recommendation. The assessor can choose to remove the recommendation of an AT or HM tier or edit the recommended AT or HM tier to align with the older person's needs.

> Note:
>
> The IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment. However, assessors must not undertake this action and delegates must not approve assessments where this occurs.
>
> Where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.)
>
> An ongoing SaH classification must be generated to override and recommend RCP for approval.

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

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

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

> Note:
>
> From 29 June 2026, Hoarding and Squalor services and Restorative Care Pathway can be recommended together (which was previously blocked), however, they remain separate programs with Hoarding and Squalor still being delivered via CHSP.
>
> Note: If the client is assessed in hospital, the Restorative Care Pathway should not be recommended. Assessors should consider appropriate alternative services.

6.2.4. Interactions with other programs

Table 25. Restorative Care Pathway interaction with other programs

Program	Interaction with Restorative Care Pathway (RCP)
Ongoing Support at Home	If an older person receives an ongoing Support at Home classification through the IAT, this can be overridden to recommend the RCP.
Assistive Technology and Home Modifications (AT-HM) scheme	Older people approved for the RCP may also require Assistive Technology or Home Modifications to support good restorative care outcomes. Assessors must always ensure these needs are considered when approving the RCP. Older people who are approved for the RCP are eligible to receive an Assistive Technology low, medium and high funding tier, and low and medium tier **home modifications**. Participants with an ongoing Support at Home classification who already have high tier home modifications funding can keep this approval, noting this approval is connected to their ongoing classification approval. Assistive Technology **Medium** Tier and Home Modifications **Medium** tier will also be added to the recommendation. The assessor can choose to remove the recommendation of AT or HM or edit the recommended AT or HM tier to align with the older person's needs.
CHSP	Though the IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment, an assessor must **not** recommend or approve the RCP for: • an older person new to the aged care system and not receiving aged care services, who is recommended CHSP by the IAT Outcome; or • an older person already accessing CHSP, who is recommended CHSP by the IAT Outcome. (Noting, where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.) If an older person accessing CHSP is recommended an ongoing Support at Home classification through a reassessment using the IAT, this can be overridden to recommend the RCP. Note: Older people can access allied health and therapy services through CHSP. Assessors can recommend reablement and/or allied health and therapy services on their support plan.

Program	Interaction with Restorative Care Pathway (RCP)
End-of-Life Pathway (or if they have recently accessed this pathway)	Cannot receive the Restorative Care Pathway at the same time (applicable for EoL, TCP and permanent Residential Care).
Transition Care Program	
Permanent Residential Care	



6.2.5. Lapse in Restorative Care Pathway access

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

- the older person's episode of RCP ends (maximum 16 weeks); or
- a person does not enter into an agreement with a provider to deliver the RCP before the access code expires (within 56 days of approval with a further 28 days if My Aged Care is contacted for an extension).

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

Assessors should explain the importance of accessing the Restorative Care Pathway within the take-up period. Participants have 56 days from approval to find a provider and commence services. If more time is needed, participants can contact My Aged Care to request an extension of up to 28 days.

6.2.6. If the participant does not commence the pathway before the take-up deadline, the approval will lapse and the pathway cannot be accessed under that approval. A new assessment will be required before RCP can be considered again. Missing the take-up deadline may significantly delay access to care.Manual oversight of Restorative Care Pathway places



RCP places are capped at 20,000 units per year across Australia, managed as around 5,000 units per quarter. There are no in-system prompts or controls to prevent the approval of RCP funding units beyond the quarterly caps. Weekly reports of approvals made are generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

Assessors will need to remain acutely aware of any communication from the department regarding RCP caps to ensure you are making informed decisions. These communications

will be the **primary tool** for identifying the number of RCP approvals made. Being responsive to these insights is essential for avoiding over-allocation.

Before recommending the RCP for approval, assessors should consider whether other service types or alternative supports - such as other Support at Home services or reablement options under the Commonwealth Home Support Program (CHSP) - could provide an equivalent level of support. This ensures that recommendations for approval are appropriate to an individual's needs.



6.2.7. Restorative care funding

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

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode. If a participant requires additional funding during a single RCP episode, the provider can submit a support plan review request. Where the relevant criteria are met, a second unit of funding (up to $6,000) may be approved to support the participant's restorative care goals (see Chapter 10 on support plan reviews).

If approved, the participant can access up to $12,000 in total funding for that episode. A participant who accesses two units of funding during the same episode is not eligible for a further RCP episode within the following 12-month period, as they have already accessed the maximum two RCP funding units available.

Any request for a second unit of funding **must be approved before the participant's current RCP episode ends**. The additional funding is intended to supplement the active RCP episode, but it does not extend the period of effect of the original approval. Once the RCP episode has ended, a concurrent second unit cannot be approved.

To access a future RCP episode, the participant would need to undergo reassessment and meet all eligibility requirements, including allowing for the minimum 90-day break between episodes.

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

Evidence to support the additional funding may include:

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

The assessment delegate must send a letter to the older person (and their registered supporter/s, if required under the Act) notifying them of the outcome of the application for the additional funding. Refer to Section 9.3.6 for more details.

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

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

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

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

6.2.9. Hospitalisation, residential respite and leave

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

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

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

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

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

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

6.3.1. End-of-Life Pathway form

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

The End-of-Life Pathway Form is required to be completed and submitted before a participant can be assessed as eligible for the End-of-Life Pathway. Assessors are responsible for ensuring they receive the completed End-of-Life Pathway Form to proceed

with the assessment. In cases where an aged care assessment or support plan review (SPR) is undertaken via telehealth (and where digital referral or GP e-referral is not used), assessors must assist older people to ensure the completed End-of-Life Pathway Form is submitted. Options for lodging the completed End-of-Life Pathway Form include:

- An older person or their support person may nominate to send the signed form directly to the assessment organisation via their preferred mechanism (for example, email). Assessors should contact the person to discuss their options and assist to obtain the form in cases where a person is unable to send the form themselves due to circumstances such as digital barriers or limited access to support; or

- Assessors contact the relevant medical or nurse practitioner to request they send the completed End-of-Life Pathway Form to the assessment organisation via their standard processes for information sharing (for example, fax)

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

Reviewing the form will involve:

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

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

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

6.3.2. Accessing the End-of-Life Pathway

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

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

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



Assessors should explain the importance of accessing the End-of-Life Pathway within the take-up period. Participants have 56 days from approval to find a provider

and commence services. If more time is needed, participants can contact My Aged Care to request an extension of up to 28 days.

If the participant does not commence the pathway before the take-up deadline, the approval will lapse and the pathway cannot be accessed under that approval. A new assessment will be required before the End-of-Life pathway can be considered again. Missing the take-up deadline may significantly delay access to care.

6.3.3. Interactions with other programs

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

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

Program	Interaction with the End-of-Life Pathway
Restorative Care Pathway	
Permanent Residential Care	

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

6.3.4. Funding for the End-of-Life Pathway

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

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

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

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

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

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

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

6.3.6. Assessing for End-of-Life Pathway

When assessing for the End-of-Life Pathway, only mandatory questions that are required to run the IAT Outcome and generate an ongoing Support at Home classification are required

to be completed. This is to ensure the older person has a valid classification to return to if they need services beyond the End-of-Life Pathway funding period. Other questions are optional based on the individual's needs and context.

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

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

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

Note: the 'Allied health and other therapeutic' service type and all the services within, as well as the 'Therapeutic services for independent living' and all the services within, will not be pre-selected. An assessor must manually select these services for them to be approved in the support plan.

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

By recommending the End-of-Life Pathway, Assistive Technology Medium Tier will automatically be added to the recommendation. The assessor can choose to remove the recommendation of AT or edit the recommended AT tier to align with the older person's needs.



Managing an IAT outcome of 'CHSP' for EoL clients

Where a CHSP outcome is generated, assessors cannot override the recommendation to the End-of-Life Pathway, as the system does not permit a CHSP outcome to be overridden to End-of-Life.

If a CHSP outcome is produced, assessors should first consider whether the outcome may have resulted from incomplete, inconsistent or incorrect information entered into the IAT. Where appropriate, assessors should use the IAT amendment process to return the assessment to draft status and review the assessment information against the End-of-Life Pathway Form and the older person's circumstances.

Where a genuine CHSP outcome is produced and the older person has an eligible End-of-Life Pathway Form, assessors should:

- finalise the assessment and accept the CHSP outcome
- immediately raise a Support Plan Review (SPR) for End-of-Life Pathway, and

- escalate the matter to the department for review by emailing MyAgedCare.Assessment@health.gov.au with the subject line beginning "EOL – CHSP OUTCOME – ADVICE SOUGHT" and marking the email as urgent.

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

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

Older people new to the aged care system who are approved for the Support at Home AT-HM scheme cannot be issued referrals to Commonwealth Home Support Program (CHSP) AT and/or HM services while they wait for AT-HM scheme funding.



An older person receiving CHSP-funded AT and/or HM who is reassessed for Support at Home and the AT-HM scheme may continue accessing these services through CHSP, provided they have existing referrals, until their AT-HM scheme budget becomes available. Once that budget is available, they will no longer be able to access CHSP-funded AT and HM services.

6.4.1. AT-HM scheme participants

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

Through the AT-HM scheme, participants will:

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

6.4.2. Assistive technology

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

Examples of assistive technology include:

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

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

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



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

6.4.3. Home modifications

Home modifications (HM) provide changes to an older person's home to create an environment that is safer and more accessible.

Examples of home modifications include:

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

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

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

The AT-HM scheme does not include:

- general renovations to a home or dwelling
- restorations or repairs which are considered normal maintenance of home or dwelling
  changes to a home layout that do not relate to a participant's assessed clinical need(s) in their support plan.

6.4.4. Funding tiers for AT-HM

The table below outlines the 3 funding tiers for assistive technology and home modifications. Indexation will be applied to the below amounts; indexation will occur on 1 July and 1 August 2026. For the latest budget information, please go to: Schedules of Subsidies and Supplements for Aged Care | Australian Government Department of Health, Disability and Ageing

Table 27. AT-HM funding tiers

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

This funding may cover the following:

- Assistive technology equipment and products
- Home modifications and associated services
- Repairs or maintenance of assistive technology items available on the AT-HM list
- Prescription of items, where appropriate, by a suitably qualified health professional working within their professional scope of practice
- Recurring AT costs including ongoing monitoring, software, subscription fees or rental costs.

- Associated administration activities (cap will apply – see the AT-HM scheme guidelines for further details).

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

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

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

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

Recurring AT costs, e.g. subscription fees, rental costs, continued monitoring costs or software costs associated with an item on the AT-HM list must be paid out of the AT-HM scheme funds. For example, personal emergency alarm systems are included on the AT-HM list. The cost of the alarm and the ongoing monitoring (including by a third party) are both covered by AT-HM funding. Ongoing monitoring costs are part of the AT-HM item. The amount paid by the participant is the same as the independence category rate.

AT-HM funding normally lasts for 12 months. If the participant still needs to pay for recurring costs, subscription fees or continued monitoring after that, the participant will need to be reassessed by an aged care assessor, who can assess the participant for a new level of AT-HM funding if needed.

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

These conditions are:

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

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

6.4.5. AT-HM list

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

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

- **managing body functions** – including pressure cushions, anti-oedema stockings and memory support products
- **self-care products** – including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- **mobility products** – including walking frames, wheelchairs and lifting devices
- **domestic life products** – including assistive products for food preparation, eating, drinking and house cleaning
- **communication and information management products** – products and equipment that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices
- **home modifications** - including accessible showers, grabrails, fixed ramps and safety barriers.

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



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

6.4.6. Assessing the need for AT-HM scheme funding

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

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

During the assessment, consider whether the older person:

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

Older Aboriginal and Torres Strait Islander people may not reveal the full care needs to service providers who they may not know or with whom they have a trusted relationship. If trust and rapport has already been built with the FNAO assessor through the assessment process or with the ECS worker, the assessor/ECS worker may (if appropriate) choose to facilitate service providers and the client with the process of identifying specific types of AT-HM which are best suited and advise on any cultural matters that may need to be considered.

6.4.7. AT-HM funding tier guide

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

The guidance has been designed to consolidate the main elements of the IAT relevant to AT-HM and support assessors in choosing a funding tier. The guide will suggest an assessment tier which should sit where the majority of tier indicators have been selected. The guide groups indicators into three tiers: **low, medium, and high**—and uses a checkbox format for ease of completion. The AT-HM tier guide provides a non-scored pattern of recommendation—the more indicators selected within a particular tier, the stronger the alignment with that level of support.

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

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

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

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

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

Assessors are asked to complete the following:

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

Assessment decisions for AT-HM funding tier allocation can be reviewed through a support plan review if the funding tier does not cover the assessed need.

CASE STUDY: AT low tier

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

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

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

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

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

CASE STUDY: HM high tier

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

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

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

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

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

CASE STUDY: Progressive Condition

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

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

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

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

6.4.9. Recommending AT-HM tiers in the assessor portal

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

From 29 June 2026, a new feature in the integrated assessment tool (IAT) will allow assessors to flag a consideration for either AT or HM throughout these categories of the assessment:

- Function (AT and HM)
- Physical personal health and frailty (AT and HM)
- Medications (AT only)
- Cognition (AT and HM)
- Social (AT and HM)
- Psychological (AT and HM)
- Home and safety (AT and HM)

If tick boxes are selected for either AT or HM in the assessment this will then be displayed in the Identified needs under other considerations on the support plan to assist the assessor in making a final decision on the assistive technology or home modifications funding tier required for the participant.

For more information, please see the IAT User Guide.

Assistive technology

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

If the recommended classification is Support at Home Restorative Care Pathway, then an **automated medium tier** will be assigned with the assessor being able to change to a low or high tier based on assessed need.

If the recommended classification is Support at Home End of Life pathway, then an **automated medium tier** will be assigned with the assessor being able to change to a low tier based on assessed need.

Assistance dogs

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

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

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

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

The IAT now captures if a participant has an assistance dog through three new questions, including if the participant is able to access the Federal Government funded Physical Assistance Dogs Program and whether the participant's assistance dog meets the definition used by Health Direct.

Home modifications

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

If the recommended classification is Support at Home Restorative Care Pathway, then an automated medium tier will be assigned with the assessor being able to change to a low tier based on assessed need.

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

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

6.4.10. AT-HM Scheme Priority System

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

Older people with **Motor Neurone Disease** (MND) recorded during their aged care assessment will be assigned **urgent priority** for access to Support at Home and receive an immediate funding allocation for AT-HM. This reflects the progressive nature of MND and the potential for a person's functional ability and support needs to change rapidly.

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

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

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

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

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

6.4.11. Interactions with other programs

Table 28. AT-HM scheme interactions with other programs

Program	Interaction with the AT-HM scheme
Support at Home ongoing	Can access funding through the AT-HM scheme at the same time.
Restorative Care Pathway	Older people accessing the Restorative Care Pathway can access: • Assistive technology: low, medium and high tiers • Home modifications: low and medium tiers An automated medium tier will be selected for both unless the assessor indicates otherwise.
End-of-Life Pathway	Older people accessing the End-of-Life Pathway can access: • Assistive technology (short-term): low and medium tiers An automated medium tier will be selected for AT. The assessor can change the AT recommendation to AT low or remove the auto-recommendation. They cannot select AT high tier.
Residential Respite	Can receive AT-HM in their home while in respite
Transition Care Program	TCP clients who have an on-going Support at Home classification will be eligible for the AT-HM scheme under Support at Home. TCP clients who are *not* currently on a Support at Home package will be able to access AT through TCP.
CHSP	Cannot access AT-HM.

Program	Interaction with the AT-HM scheme
	Older people with a CHSP classification will access Equipment and products and/or Home adjustment services under CHSP.
Permanent Residential Care	Cannot access AT-HM

6.5. Commonwealth Home Support Program (CHSP)

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

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

CHSP will be extended for another two years to 30 June 2029.

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



CHSP service catalogue 2025-2027

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

6.5.1. Care Finder program and Elder Care Support program participants

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

Elder Care Support program

Care Finders program

6.5.2. Access to CHSP services

- An older person seeking CHSP services must be approved through an aged care needs assessment.
- Once the assessment has been finalised, based on the information entered into the IAT, the My Aged Care assessor portal or Aged Care Assessor App will indicate whether the client requires CHSP or Support at Home (SAH) services.
- If the IAT Outcome is CHSP, the assessor will proceed to recommend services.
- When assessors also recommend **urgent services** or periods of time-limited reablement under CHSP, they are requested to record any additional information about the client's situation in the assessment summary, as comments entered in the My Aged Care assessor portal will not appear on the Support Plan.
    - For example, "client needs urgent transport services until 28 February 2026 to purchase groceries/attend medical appointments, as they are unable to drive while recovering from acute episode/surgery".
- **Urgent service referrals** should cease where the assessment outcome is ongoing CHSP services, and new service referrals must be issued. The recommendation should explain why ongoing services are needed for the client (e.g., 'due to an ongoing health condition'). Ensure the explanation is justified, well-evidenced and consistent with the 2025 – 2027 CHSP Manual.
- If there is a significant change in the client's needs, they should be reassessed to determine if they should continue accessing services through CHSP or are better suited to Support at Home.
- There are some existing CHSP clients who have never been assessed for services. This includes clients who have been '**grandfathered'** into the CHSP from previous programs. It is a requirement for all clients to be referred for an assessment, even if they are already accessing CHSP services. These CHSP clients need to be directed to contact My Aged Care or their provider and be referred for an assessment to continue receiving services if eligible.
- Unassessed clients, including those who choose not to be assessed, need to move to full fee-for-service arrangements if they wish to continue accessing aged care services.
- If the client has pre-existing CHSP referrals in My Aged Care, and those services are approved in an assessment, the **referrals must be reissued by the assessor.**

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

6.5.3. Hoarding & squalor assistance

Hoarding and squalor assistance aims to support clients who are experiencing symptoms of hoarding disorder or are living in severe domestic squalor. Under the CHSP it is intended

these services are accessed by individuals on a low income, who are living with hoarding behaviour or in squalid conditions, and are at risk of homelessness.

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

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

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

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

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

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

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

Hoarding and squalor assistance does not include:

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

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

6.5.4. Understanding AT and HM under CHSP

Equipment and products and Home adjustment services are available to eligible people through the CHSP. An annual subsidy cap applies:

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

- Home adjustments: home modifications up to $15,000 per year.

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

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

Note: Unlike the Support at Home AT-HM scheme, AT and HM services under CHSP are not assigned a funding tier.

Equipment and products

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

Home adjustments

- Home modifications

6.5.5. Interactions between CHSP and other programs

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

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

Current CHSP clients can continue to access CHSP services they are already approved for, including Equipment and products and Home adjustments, while waiting for funding to be approved under the Support at Home AT-HM scheme. Once services are accessed through the AT-HM Scheme, Support at Home participants will no longer be able to access these services under CHSP.

Table 29. Guide to approving concurrent CHSP services with other government funded programs

Program	Can participant access CHSP services?
Support at Home participants (including participants who have accepted a Minimum Service Offer)	There are five circumstances only where a current Support at Home participant (including those who have accepted a Minimum Service Offer) can access services through CHSP. **Access is only available** where the assessor identifies one of the five below criteria, supports it with appropriate evidence, and documents it for the Assessment Delegate's consideration of part of the decision-making process. These are: 1. Pre-existing CHSP social support group 2. Hoarding and Squalor 3. Cottage respite, Community and centre-based respite and Flexible respite 4. Urgent short-term services (this **does not include** CHSP equipment and product services or home adjustments services) 5. Specialised support service (Vision advisory services only)

Waiting for a Support at Home place allocation	A **current CHSP client** can continue using approved CHSP services, including equipment and products and home adjustments, while they wait for ongoing Support at Home funding (including Minimum Service Offers) or AT-HM scheme funding. A **current CHSP client** may be approved for additional CHSP services on **an interim basis** until Support at Home funding begins. All CHSP services must then cease, except approved Hoarding and Squalor, Cottage Respite, and Specialised Support Services (Vision Advisory Services), which are not currently available through Support at Home. Once AT-HM scheme services commence, the person is **no longer a CHSP client** and cannot access those services through CHSP. They may, however, continue receiving other CHSP services *until* their ongoing Support at Home services commence. **New aged care participants** awaiting Support at Home funding may be approved CHSP services on an **interim basis** until their Support at Home services commence. **This excludes** CHSP Assistive technology and Home modifications. **New aged care** participants waiting for AT-HM scheme funding **cannot** access equipment and products or home adjustment services through the CHSP. These services are only available through the AT-HM scheme once funding has been allocated. If a participant's needs change and they require AT-HM that was not approved at their assessment, they can request a Support Plan Review (SPR) to determine whether reassessment is needed. Urgent equipment and product services, or urgent home adjustments **are not** available through the CHSP for people approved for Support at Home and AT-HM scheme and waiting for funding.
Residential Aged Care	Approved residents of residential aged care facilities cannot access subsidised CHSP services

Disability Support for Older Australians, National Disability Insurance Scheme (NDIS), NATSIFAC Program, Transitional Care Program (TCP) and Veterans' Home Care Program	 Clients may receive CHSP services if they have a referral for each service and there is no duplication with services they already receive through these programs.

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

1. Pre-existing CHSP social support group	Support at Home participants who have transitioned from the CHSP may continue to access their pre-existing CHSP social support group through the social support and community engagement service on an ongoing basis to allow the continuity of social relationships. This *only applies to* participants attending a **pre-existing** CHSP social support group service.
2. Hoarding and Squalor	Support at Home participants who are living with hoarding behaviour or in a squalid environment who are at risk of homelessness or unable to receive the aged care supports they need, can access time-limited Hoarding and Squalor services through the CHSP (in addition to their Support at Home funding) **via reassessment**.
3. Community and centre-based respite, Flexible respite and Cottage respite	Support at Home participants may access additional planned respite services through the Home or community general respite service or Community cottage respite.
4. Urgent services	In situations where a Support at Home participant has an urgent and immediate health or safety need, and their individualised budget has been fully allocated or they are waiting for their budget allocation, some additional time-limited CHSP services can be accessed on a short-term basis. This does not include equipment and product services or home adjustments services.
5. Specialised support services (Vision advisory services)	Support at Home participants may access Vision advisory services under Specialised support services on an ongoing basis to receive the aged care supports they need.

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

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

If an older person is approved for one of the Support at Home classification levels **and has not previously** been approved for funded aged care services in the home support service group, they can be referred to a CHSP provider to access approved services while they wait

for the Support at Home place to be allocated, **without** having an assigned CHSP classification level (CHSP class).

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

6.5.7. Time-limited definition

Short-term or time-limited services are defined according to the unique circumstances and requirements of each client. Generally, services provided for up to two months are regarded as short-term.

6.5.8. Wellness and reablement under CHSP

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

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

For further guidance taking a wellness and reablement approach through CHSP, see 'Delivering Time Limited Reablement' section in Chapter 5: Assessment activities.



Department of Health, Disability and Ageing website:

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

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

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

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

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

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

6.6.1. Assessing for NATSIFACP

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

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

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

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

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

6.6.2. Recommending NATSIFACP pathway

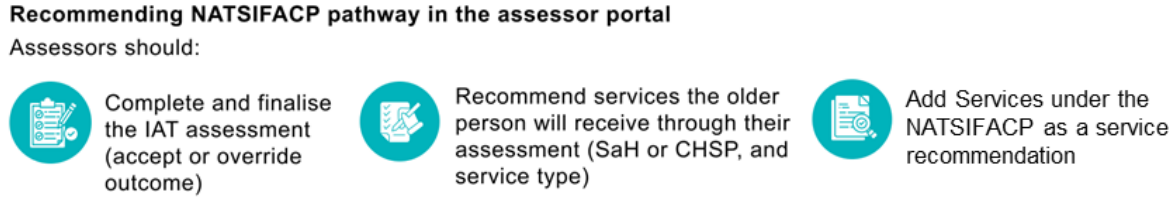


Figure 5 – recommending NATSIFACP pathway in the assessor portal

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

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

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

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

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

6.6.3. Interactions with other programs

All service groups and types can be delivered under NATSIFACP.

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



For further information, please refer to the NATSIFACP Manual.

6.7. Multi-Purpose Service Program (MPSP)

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

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

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

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

6.7.1. Assessing for MPSP

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

6.7.2. Recommending MPSP pathway in the assessor portal

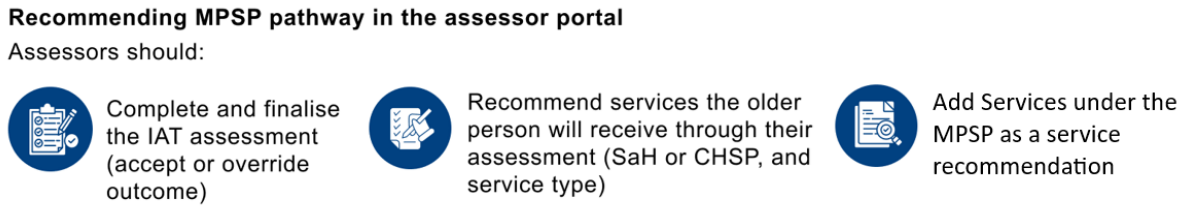


Figure 6 – Recommending MPSP pathway in the assessor portal

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

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

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

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

6.7.3. Interactions with other programs

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

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

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



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

6.7.4. Referrals to NATSIFACP and MPSP providers

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

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

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

Assessment delegates are responsible for approving service recommendations.

> Important
>
> It is not sufficient to only make a service recommendation of Services under the MPSP or Services under the NATSIFACP, as an individual cannot access services under these programs without an access approval from a delegate for one or more service groups.
>
> If the client has been approved for home support with an ongoing Support at Home (SaH) classification or for the AT-HM scheme but intends to initially access services through their local MPSP or NATSIFACP provider, the assessor should set the 'Seeking Services' field to 'No' for one or all of these recommendations as needed. This must be confirmed with the individual before selecting the field. This will prevent the individual from being added to the prioritisation queue(s) for these services and being offered a place which they do not intend to accept at that time. You should not do this if you expect the older person will need to concurrently access services from both the MPSP/NATSIFACP and SaH program and/or the AT-HM scheme.

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

- the Services under the MPSP or Services under the NATSIFACP service recommendation is recorded in the Notes section (as well as being a service recommendation in the support plan)
- the support plan

6.8. Transition Care Program (TCP)

Transition care is available to older people following admission to hospital. The program is delivered under the service groups home support, assistive technology, and residential care**.** Transition Care is designed to support individuals in the period immediately after discharge from hospital. It aims to facilitate recovery, improve functional capacity, and

provide time and support in a non-hospital environment while long-term care arrangements are being considered.

Services include:

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

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

6.8.1. Access to transition care

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

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

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

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

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

6.8.2. Recommending transition care

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

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

The client will then have access to all of the required Transition Care service types under each service group, to allow them to receive transition care across different care settings including their home/in the community and Residential Care or a mixture of both. The

Assessor and Assessment Delegate are not required to action any additional tasks such as selecting service types within the system in order for the client to be approved for all of the service groups above. These service group approvals will appear in the Notice of Decision Letter.

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

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

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

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

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

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

6.8.3. Accessing Transition Care Program with Support at Home or CHSP

An older person can be recommended and approved for CHSP or Support at Home services at the same time as TCP, provided the IAT Outcome generates an ongoing home support outcome. For example, Support at Home services can only be recommended if the IAT Outcome generates a SaH 1-8 classification level. The assessor must accept the IAT Outcome in line with 81-10 of the Rules.

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

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

For transitioned HCP, SaH clients and CHSP clients who are assessed for TCP, the IAT Outcome will need to be accepted, and TCP added as a care type.

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



For a new client who requires TCP without any ongoing home support services, an assessor can still override the IAT outcome and select 'ineligible for CHSP/SaH' and then select TCP via 'Add a care type for Delegate Decision.' Note that CHSP services will not be able to be selected, unless the assessor accepts the ongoing home support outcome.

6.8.4. Accessing residential care/residential respite and transition care

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

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

6.8.5. Duration of transition care

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

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

Lapsing of transition care approval

A transition care approval will lapse under the following circumstances:

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

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

Breaks in care

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

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

6.8.6. Transition care extensions

If an individual is still making functional gains and would benefit from additional time in Transition Care, the Transition Care provider can request an extension of up to 42 days, with the potential for a further 42-day extension if clinically appropriate.

To initiate the process, the Transition Care provider must submit an extension request via the My Aged Care Service and Support Portal to the assessment organisation. This request must be submitted before and approved by the 84th day of the care episode. The request should include the reason for the extension, the duration requested, and any supporting information relevant to the individual's ongoing care needs. Note there is no right of review if an extension request is declined.

The assessment organisation will receive and action the request through the My Aged Care Assessor Portal. The Assessment Delegate will be responsible for reviewing and making a decision on the request.

When recording a decision to approve an individual for Transition Care, a drop-down box will require the assessor to select a priority. There is no priority system in place to receive services through Transition Care, and the priority value will not impact the timeliness of receiving these services. For consistency, assessors are required to set the priority to 'high' for all assessments.



Transition Care Program Guidelines – November 2025 | Australian Government Department of Health, Disability and Ageing

6.9. Residential care

Residential aged care is a care type that can be recommended to an older person. There are two types of residential care: ongoing (permanent) and short-term (respite).

An ongoing residential care approval does not compel an older person to enter residential care, it simply enables a person to commence residential care services if and when they choose to do so, without the need for further assessment.

Matters relating to residential care must be decided with the consent of the older person, and if they do not have capacity, their appointed decision maker recognised under the Act

(whether or not that person is a registered supporter). Appointed decision makers must have authority to make any decisions relative to residential care, and that authority must be active.

Where possible, older people should be supported to live in their community for as long as possible. An assessment may, however, identify residential care as a suitable option for an older person who is no longer able to be adequately cared for by carers or family, and is incapable of living in their community without support.

Application and approval for residential care means the person meets the eligibility criteria and the care type is appropriate for their care needs. To be approved for residential care a delegate must be satisfied that section 68 of the Act applies to an older person (except for older Aboriginal and Torres Strait Islander people who access services on a different constitution basis). The older non-Aboriginal and Torres Strait Islander person must require aged care services due to their sickness as defined under the Act. For further information on the Act's definition of sickness and approvals under sections 67 and 68, refer to section 7.6.4 of Chapter 7.

On 1 October 2022, the Australian National Aged Care Classification (AN-ACC) residential care funding model replaced the Aged Care Funding Instrument.

Following an older person's admission to residential care, a residential aged care funding assessor (RAC funding assessor) will conduct an assessment using the AN-ACC assessment tool. The assessment information is uploaded and is used to determine the resident's classification.

A person who is eligible for residential care may require daily assistance with:

1. meals (including special diets)
2. bathing, showering, dressing and personal hygiene
3. toileting and continence management
4. general nursing care (e.g. wound management)
5. organising and taking medication
6. communication (including fitting sensory or communication aids)
7. transfers and mobility
8. assessment and referral for appropriate health services; and/or
9. emotional support

If an older person's concerns and goals identify the need for residential care, ongoing and short-term residential care can be added to a person's support plan through the 'add care type' button on the *Goals & recommendations* tab.

An assessor will need to consider the person's:

- physical needs – how much support does the person need for daily living activities (i.e. preparing meals, eating, showering, dressing etc.) their level of mobility and whether they need assistance to walk, sit and stand
- health needs - does the person have chronic health issues that require nursing intervention or regular clinical/medical procedures
- cognitive needs – does the person have issues with memory, orientation, or thinking abilities? is there a diagnosis of dementia?
- psychological and wellbeing needs – do they have any symptoms of depression, anxiety or other mental health challenges, or isolation. Is there a strong social support network for the person
- current living arrangements – what is their living situation and is their living environment safe, do they have family and friends for informal support

- carer impacts – does the carer need a break and would respite support the person's wishes to stay in their own home longer

There may be a combination of any of the above needs or factors, or a single need that results in the assessor determining that an individual is incapable of living in a home or community setting without support (*Aged Care Rules 2025* Section 65-20 eligibility requirement – service group residential care) and has a continuing need for funded aged care services, including nursing services (*Aged Care Act 2024*, Division 3, Section 68).

6.9.1. Recommending residential care

If an assessor recommends that a client only receive ongoing residential care and/or short-term residential care, there are two pathways to consider when recommending these services:

- An assessor can choose to override the IAT Outcome to 'ineligible for CHSP/SAH' and then choose Residential Permanent and/or Residential Respite options under the 'Add a Care type for Delegate Decision' button
- An assessor can accept a 'SaH Classification' or 'CHSP' IAT Outcome, then choose Residential Permanent and/or Residential Respite from the 'Add a care type for delegate decision' button. The assessor must then ensure that the Support at Home classification is switched to 'not seeking services' and kept as a latent class. This provides the client with flexibility in case they want to return home in the future and access home support services.

6.9.2. Priority for ongoing residential care

To meet the requirements of the *Aged Care Act 2024*, an older person being approved for permanent residential care will be assigned a priority category (1, 2 or 3). Although important, the priority category will not impact when a person can access residential care services or services under a specialist aged care program.

Table 31. Description of priority categories

Category	Description
1	The person: • has a high urgency rating; or • resides in a rural or remote area classified as MM 5, MM 6 or MMM 7; or • is Aboriginal or Torres Strait Islander, homeless, or is entering residential care due to emergency circumstances.
2	The person does not meet the criteria for Priority Category 1 and has a medium urgency rating.
3	The person does not meet the criteria for Priority Category 1 and has a low urgency rating.

The priority category is automatically generated by the assessor portal based on the individual's circumstances, urgency rating and in accordance with the criteria specified by the *Aged Care Rules 2025*.

Assessment Delegates will need to verify that the urgency rating assigned to the individual accurately reflects their needs and are supported by the evidence provided.

6.9.3. Urgency rating for residential care

A person's urgency rating is different to their need for residential care. While it is expected that all people with a recommendation for residential care have been assessed as having high-level care needs, their level of urgency indicates the extent to which a person may be at immediate risk, including to personal health and safety, if they are not admitted to residential care within a timely manner.

This rating will not undermine the older person's ability to choose to remain in their home but will provide a guide for providers of residential care homes and others (such as Care Finders) to prioritise people who may be most at risk.

When selecting 'Residential Permanent' under the 'Add a care type for Delegate decision' in the My Aged Care assessor portal, assessors will be required to give a response to 'What is the urgency of this care type.' This question is a mandatory question with a rating to be selected from high, medium or low.

The Rules specify when an urgency rating of low, medium or high will apply to an individual in relation the classification type ongoing for residential care. The table below summarises the criteria for each urgency rating.

Provide a rating (low, medium or high) which balances objective consideration of needs with the subjective perspective of the older person. The older person's perspective may be conveyed by their registered supporter. Include a brief note in the *reason or comments* section explaining key reasons for the rating, which may include:

- Key individual, care related or contextual needs and how these relate to any safety/wellbeing risks
- Whether the older person/ has expressed an urgent need to enter care
- Perspective on estimated timeframe the older person needs to enter care

Relevant factors to consider in determining urgency may include:

- Current care settings (including if the person is transitioning into residential aged care from hospital or residential respite care)
- Significant and visible decline in the level of function, cognition and/or ability to perform activities of daily living in the home with available support
- Health conditions and ability to manage these in the home with available support
- Severe incontinence that cannot be managed within the current care settings
- High risk to personal safety (e.g. hazardous home environment, high risk of falls, wandering, or elder abuse)
- Complex factors, including but not limited to homelessness or risk of homelessness; drug and alcohol abuse; mental health issues; or severe social isolation
- Lack of available and sustainable formal, informal support (including any impacts on carers)

The following can be used as a guide to what urgency may look like within each category. Examples are provided for demonstrative purposes only and each case will need to be judged independently based on diverse individual factors.

Table 32. Guide to urgency ratings for residential care

Level of urgency	Description
High urgency	**This rating applies if:** • The individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk. **Indicators**: Recent falls, hospital admission, unsafe to return home, severe decline. **Example**: A client in hospital post-fall who lives alone and whose needs exceed Home Care supports. Example: John has an ongoing Support at Home classification 8. He recently had a fall and is currently in hospital. John feels like he is unable to return home, and the hospital requests an urgent aged care assessment. The outcomes of John's assessment reveal several risk factors. His health and function are declining, and he has experienced several incidences of falls in recent months leading to hospital admissions. He lives alone, feels socially isolated and needs substantially more hours of care than is possible through the formal support he can receive through Support at Home. The Assessment Delegate approves John for ongoing residential aged care services, with a high urgency rating.
Medium urgency	**This rating applies if:** • The circumstances for a high urgency rating do not apply to the individual; and • When considering the individual's circumstances and preferences, the individual is expected to seek access to permanent residential care within the next 6 months. Example:

Level of urgency	Description
	Mei has been receiving CHSP services for a few years and recently requested a support plan review to have her needs and services reviewed. As her needs have increased, and she has some complex factors, including declining cognition and moderate incontinence, a reassessment was arranged by the assessor. Mei's daughter, Tao, is her primary carer and is becoming overwhelmed. She's concerned about how much longer Mei will be able to remain living at home by herself, should her cognition and incontinence deteriorate. Mei speaks to her GP and requests a reassessment. The assessor has a conversation with Mei and Tao about the option of ongoing residential care, and they agree that Mei will likely move into an aged care home within the next three to six months. Mei is approved for ongoing Support at Home as well as ongoing residential aged care services, with a medium urgency rating.
Low urgency	**This rating applies if**: • The circumstances for a high or medium urgency rating do not apply to the individual. Example: Maria has been receiving CHSP services in her home. She can still complete many basic and daily living tasks without help but has had a few minor falls recently and is becoming less mobile around the house. Through a reassessment, an ongoing Support at Home classification is approved to meet her current needs. She's feeling very lonely as many of her friends in the community have already moved into aged care facilities, and her children live interstate. She is worried that she might have another fall and need to move into an aged care home. Maria's son agrees to move in with her to provide informal care for 6 months, but she knows that she'll probably need to move into residential aged care once he leaves. Maria is approved for ongoing residential aged care, with a low urgency rating.

Clients residing in rural and remote areas

IT System enhancements have been built to map a client's residential address to their relevant Modified Monash Model (MMM) 2023 region which is needed to determine their priority. This will be completed automatically for every client approved for residential aged care.

If the client is being assessed in a temporary location, the address where the client is generally located should be used. If the older person is being assessed in a city whilst staying with family, this will greatly skew the urgency rating.

When an older person registers with My Aged Care, they will be prompted to enter in relevant contact details including their home address. If a home address has not been inputted or is incorrect, an assessor may input or update a clients address at the time of assessment. This is a mandatory field as part of My Aged Care registration/assessment. If you update the individual's address, you will need to click on the 'validate this address' button to populate the MM classification.

A yellow text box may appear when residential care is added or edited as a care type in the *'goals and recommendations'* section of the support plan and the MM classification has not been mapped to the individual's record. The yellow box will seek to update the clients address in their record or manually select the appropriate Modified Monash (MM) area.



Modified Monash Model | Australian Government Department of Health, Disability and Ageing

6.9.4. Place allocation

The residential care system allocates residential care places (permanent or respite) directly to older people. This is the 'Places to People' reform.

Places will be assigned directly to older people who can then access government-funded residential care services. This will give them more choice and control over what provider delivers their services.

Mainstream residential care providers will no longer need an allocation of places to deliver government-funded aged care services.

Providers that deliver residential aged care through a specialist program (such as MPSP or TCP) will still get allocated places, for further information see resource below.



Places to people – Embedding choice in residential aged care | Australian Government Department of Health, Disability and Ageing

If a person has been approved for residential care, (permanent or respite), they will be allocated a place immediately. They will be advised on this in the Notice of Decision letter.

There will be no delays to allocate the place. Once the person has their place it stays on their My Aged Care account and will not be withdrawn. There are no time limits for when people need to enter into care.

6.9.5. Exiting residential care

If an individual has an existing transitioned Home Care Package or Support at Home approval and chooses to exit residential care, they can rejoin the Support at Home Priority System queue by:

- being formally exited by their residential care provider in the Services Australia system
- calling My Aged Care and requesting to opt back in, once formally exited.



Interaction with Support at Home

An older person can only access Support at Home or Residential Care at a single point in time. This means, if they are in permanent residential care, they can't access Support at Home services. If an older person is receiving Support at Home services, it's important to understand that entering permanent residential care will automatically withdraw their active Support at Home services.

There are no leave arrangements under Support at Home. This means if an older person is receiving Support at Home services and plans to enter short-term residential (respite care), they can temporarily stop receiving services to access short-term residential care.

Where an older person was approved for Support at Home and permanent residential care but is only accessing permanent Residential Care, the older person can opt back in to the Support at Home Priority System and wait for a Support at Home place while they are in Residential Care if they plan to leave once their Support at Home funding is assigned.

Where an older person in permanent residential care expresses an intention to return to their home, assessors should not defer assessment solely because the person is not currently residing in their home. Assessors should assess the person's likely care and support needs on the basis of their intended living arrangements following their return to the community, taking into account any risks, functional limitations and supports that may be required to enable them to live safely and independently at home.

If a person enters Residential Care while waiting in the queue for the higher classification to be allocated, they can choose to remain in residential care and stay in the Support at Home Priority System queue for their higher Support at Home classification. Funding will be assigned according to their place in the queue and the current Support at Home allocation rules. They can continue receiving residential aged care services until their higher-level Support at Home funding becomes available.

Alternatively, they can leave residential aged care and return to Support at Home under their previously allocated lower classification level, which will be allocated immediately. This allows them to access Support at Home funding and services without delay. Once they have re-entered Support at Home services at the lower classification, they can request to rejoin the queue for their approved higher classification, while continuing to receive Support at Home services. Their original queue entry date for the higher classification will be retained, so they do not lose their place in the queue while waiting for higher level funding.

6.10. Residential respite care

Short-term (respite) care is provided as an alternative care arrangement with the primary purpose of giving a carer or an individual in need of care a short-term break from their usual care arrangement. Residential respite is not intended as an alternative to restorative care.

Older people will continue to be able to access emergency respite care through the alternative entry pathway, even if they have not been assessed and approved for short-term residential care.

6.10.1. Recommending residential respite care

When recommending an individual for residential respite care, assessors should complete the De Morton Mobility Index – modified (DEMMI-modified) assessment. This tool assesses the individual's mobility and determines their eligibility for one of three respite funding classes: Respite class 1, Respite class 2, Respite class 3, based on the level of mobility observed.

The DEMMI-modified assessment is available within the IAT and can only be used as part of a comprehensive assessment, as it must be completed by a clinically trained assessor. A non-clinical assessor cannot complete the DEMMI-modified even with clinical attendance.

The question, '*Are you likely to recommend residential respite care*' in the IAT is only available in comprehensive assessments. Assessors who are completing a home support assessment and likely to recommend residential respite must convert the assessment to a comprehensive assessment.

If the DEMMI-modified assessment cannot be completed at the time of assessment, the individual will be temporarily assigned a default funding class (Class 0). This classification remains in place until a formal RAC funding assessment is carried out within the residential aged care home, by a RAC funding assessor, at which point the appropriate funding class can be determined based on the individual's assessed mobility.

> Note:
>
> Approvals for short-term residential care will not be prioritised. When you view the care type recommendation for Residential Respite Care, you will see the 'Urgency' field has been automatically set to 'High' and cannot be edited.

6.10.2. Extensions for residential respite

Assessment delegates may receive requests for a 21-day extension to residential respite care —for example, when a carer is unwell or temporarily unable to resume their care responsibilities. There is no limit to the number of extensions that may be granted beyond the standard 63 days of respite care per financial year.

Typically, the residential aged care provider submits the extension request via the My Aged Care Service and Support Portal, and the assessment organisation receives it through the Assessor Portal for the assessment delegate's action.

An assessment delegate's responsibility is to review the request and either approve or decline it. Once a decision is made, they must communicate the outcome to the provider.

The assessment delegate will need to be satisfied that an increase in the number of respite days was necessary due to any of the following:

(a) carer stress

(b) severity of the individual's condition

(c) absence of the individual's carer

(d) any other relevant matter (for example, where a provider delivers an episode of respite care in good faith but subsequently finds out the care recipient's allocation of respite days had already been exhausted).

Note: There is no right of review if an extension request is declined.

Once decided, the assessment delegate must give written notice to the registered provider of your decision whether to extend within 28 days after the application was made. This written notice must include the day the decision takes effect, which may be before the day the decision is made.

Extensions are granted only at the previously approved level of care. If a higher level is needed, a reassessment and new approval by a Clinical Assessment Delegate is required before the extension can be granted

Where multiple extensions are being requested in one financial year, the assessor should review the Support Plan in consultation with the client, family and provider, to confirm the appropriateness of the residential respite care with the possibility of considering other care options. This will include whether there is an appropriate Support Plan in place to safely support the person to return home following the residential respite care episode (see section: Residential Care).

 **For more information on managing residential respite extensions, refer to** Managing residential respite care | Australian Government Department of Health, Disability and Ageing

6.11 Other programs and supports

6.10.3. Dementia specific programs and supports

Counselling, education, information, and other support for people living with dementia or experiencing cognitive decline, and their care partners, families, and representatives is available through the National Dementia Support Program (NDSP), delivered by Dementia Australia. They can be contacted 24 hours a day, 7 days a week via the National Dementia Helpline on **1800 100 500** or by visiting the Dementia Australia website.

Chapter 12: Supporting diverse experiences and needs, outlines a system to refer carers of older people living with dementia or experiencing cognitive decline to the National Dementia Helpline, with their consent. A trained professional from Dementia Australia will call the older person and speak to them about dementia-specific services and supports that might assist to help improve or maintain their quality of life.

Note:

A person does not need to have a formal dementia diagnosis to be referred to Dementia Australia for support.

6.10.4. Dementia Carer Respite and Wellbeing Program

The Dementia Carer Respite and Wellbeing Program (also known as the Staying at Home program) delivers models of respite care through a shared respite experience, attended by both the person living with dementia and their care partner.

The program expands on existing supports to:

- maintain or improve quality of life for care partners and people living with dementia
- increase care partner knowledge, skills and capability to care for a person living with dementia at home improve the experience and quality of respite care for care partners and people living with dementia
- support people living with dementia to stay at home for longer
- provide peer support connections for care partners and people living with dementia

Care providers (supported by Dementia Support Australia) deliver the Staying at Home program. Family carers can find more information about the program on the Dementia Support Australia website.

There are also a small number of dementia specific innovative respite care programs being trialled across Australia.

6.10.5. Dementia behaviour support

The Australian Government funds national dementia behaviour support programs through Dementia Support Australia (DSA) to support carers and service providers, which can be accessed by contacting the 24-hour DSA helpline on **1800 699 799**.

Dementia Behaviour Management Advisory Service (DBMAS), delivered by DSA, provides free personalised support and advice to service providers and individuals caring for people with dementia in any location or setting in Australia. It provides support when the behavioural and psychological symptoms of dementia (BPSD) start to impact a person's quality of care. DBMAS assists carers and service providers to understand the underlying causes of behaviour, promotes person-centred and trauma-informed approaches, and assists with practical strategies to reduce distress, use of restraints, and inappropriate responses to behaviour.

Severe Behaviour Response Teams (SBRT), also delivered by DSA, provide urgent, specialist outreach support where behaviours are severe, persistent or place the person or others at significant risk. It offers free support and advice to approved aged care providers where there is heightened severity of BPSD or risk to the person living with dementia, or their care network. SBRT may provide onsite assessment (or virtual support where appropriate), multidisciplinary clinical input, and short-term intensive interventions. SBRT will partner with the person living with dementia and their care network to identify unmet needs, contributing factors, and appropriate strategies to stabilise behaviour and support continuity of care.

The **Specialist Dementia Care Program (SDCP)** supports people with very severe BPSD whose support needs cannot be met in a residential aged care home. Care is provided in a

small unit in a cottage-like dementia friendly environment. The program enables specialised care in circumstances where the person has very severe BPSD complicated by physical aggression or other behaviours that the person's residential aged care home or carer partners cannot manage, even with help from other services.

The program provides transitional care aimed at stabilising behaviours over approximately a 12-month period to enable the resident to transition to a less intensive care setting when they no longer need SDCP care.

Referral and eligibility for the program is undertaken by Dementia Support Australia (DSA) through the Needs Based Assessment service.

The **Hospital to Aged Care Dementia Support Program** helps older people living with dementia transition from hospital into residential aged care or home with aged care support. The program supports hospital and aged care staff, the older person and their family or carers:

- during their hospital stay
- when transitioning out of hospital
- following hospital discharge into an aged care supported environment for up to 3 months

DSA are delivering the program in select locations across all states and territories and referrals are accepted from hospital staff in participating hospital sites.

A HACDSP program framework has been developed and provides high level program overview, scope, and administrative arrangements and is available by emailing HACDSP@health.gov.au

A list of current locations and participating hospital sites, along with information on program eligibility and referral processes, is available on DSA's website Hospital to Aged Care Dementia Support Program (HACDSP)



Dementia Support Australia

Staying at Home

Assessing for Eligibility for the Specialist Dementia Care Program (SDCP)

Specialist Dementia Care Program information booklet

6.10.6. Department of Veterans' Affairs (DVA)

Veterans have the same right of access to community and aged care programs as any other member of the community. The *Aged Care Act 2024* lists veterans under the Statement of Principles (section 25). Veterans should not be discriminated against or refused care when accessing services from other community and aged care programs on an assumption that DVA will provide for all their care needs. DVA provides some entry-level care services but does not provide higher-level care services.

Veterans' Home Care (VHC) Program

Veterans' Home Care (VHC) is a DVA program designed to assist veterans and war widows/widowers who need a small amount of practical help to continue living independently in their own home. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance. VHC is not designed to meet complex or high-level care needs.

Community nursing (CN)

CN provides clinical nursing and/or personal care services to eligible members of the veteran community in their own home. CN services can assist with medication, wound care, hygiene and dressing. CN services can help to restore or maintain health and independence at home and assist to avoid early admittance to hospital or residential care. Veterans requiring high-level care require prior approval by DVA.

CN services are provided by a mix of personnel including registered and enrolled nurses and nursing support staff, who work within the framework of their relevant national standards.

Duplication of services

As long as there is no duplication of services between the programs, Veterans may access DVA's VHC and CN services at the same time as accessing **different services** from:

- Ongoing Support at Home
- CHSP
- TCP

For ongoing Support at Home, this access can occur regardless of the level of the package.

CHSP offers services that are not available through the VHC Program or other DVA arrangements, such as a wide range of social support, food services, community transport and centre-based day respite.

Assistance with fees

DVA may assist with the cost of fees for government funded aged care services for veterans, depending on the type of aged care and the eligibility of the veteran. We recommend the older person contact DVA on 1800 838 372 to check if they are eligible for assistance. If the person is a Prisoner of War or Victoria Cross recipient that served with the Australian Defence Force, DVA may provide additional fee assistance.



- Department of Veterans' Affairs
- Care at home and aged care services
- Community nursing
- Community Nursing Services and Providers

6.10.7. NDIS participants

For NDIS participants who have turned 65 requesting access to CHSP, assessors must ensure a person is not referred for services they are already receiving through the NDIS and/or other Commonwealth, state, territory or local government programs.

An assessment delegate should be aware of and advise NDIS participants that under the *NDIS Act 2013* (NDIS Act) an under 65 NDIS participant can remain in the NDIS if they are an aged care recipient who subsequently turns 65. However, a NDIS participant whose first permanent entry to residential care or home care (but not residential respite care) is after the age of 65, ceases to be a NDIS participant. (NDIS Act section 29 (1)(b)).

6.10.8. Disability Support for Older Australians (DSOA) and aged care

The Disability Support for Older Australians (DSOA) Program commenced on 1 July 2021. It is a closed program with no new participants and provides funding for a range of services including Assistance in Supported Independent Living, Assistance with Self-Care Activities, Specialist/Behavioural Intervention Support, Therapy, and Case Management.

DSOA supports older Australians with a disability who cannot be supported by the in-home aged care system and were not eligible for the NDIS when it was rolled out in their region.

Under changes to the *Aged Care Rules 2025* from 29 June 2026, assessors can approve Disability Support for Older Australians (DSOA) clients for CHSP only, even if the IAT Outcome is a Support at Home classification. Selecting a CHSP outcome means the DSOA client can continue to receive their DSOA services alongside the CHSP services listed below.

Should a DSOA client want a Support at Home classification, the assessor should ensure the DSOA client is informed of the considerations relating to their DSOA funding and supports when they consent to proceed with the aged care assessment. DSOA clients must confirm they understand that if they want to be deemed eligible for aged care services under Support at Home rather than CHSP, their DSOA funding will be capped, or they may be required to exit the existing DSOA program.

The following services under CHSP can be accessed by DSOA clients at the same time as DSOA:

- Hoarding and squalor assistance
- Social support and community engagement (Social Supports Group and Individual)
- Equipment and products
- Home adjustments
- Domestic assistance (General house cleaning and other approved household activities)
- Home maintenance and repairs (Home and Garden Maintenance)
- Meals
- Transport
- Specialised support services (Vision advisory services)

Specialist aged care services also do not affect DSOA funding (i.e. TCP).

All other assessment outcomes will affect DSOA funding, and will do so in the following ways:

- An assessment for permanent Residential Aged Care will result in DSOA funding being capped at current levels. This also applies to CHSP service referrals not listed above. If a DSOA client is assessed as eligible for Support at Home and commences services, they will be required to exit the DSOA Program from the date aged care services commenced. These dates will be verified through My Aged Care.

- If a client commenced their Home Care Package prior to 1 July 2021 and are a transitioned HCP care recipient under SaH, they can continue in the DSOA Program. However, their DSOA funding will remain capped.
- If a client commenced CHSP services that are available through the DSOA program, they will be required to exit the DSOA Program from the date the aged care services commenced. These dates will be verified through My Aged Care. However, if a client commenced CHSP services, which are not available via the DSOA program, **prior to 30 June 2021**, the client can continue to access these services as a grandfathered support without any impact to their DSOA funding.

If an assessor receives a referral for a DSOA older person, they should:

- establish if the older person has advised their DSOA service coordinator (provider) that they are seeking a referral for an aged care assessment;
- establish if the older person discussed with their DSOA service coordinator their options to increase supports under the DSOA Program prior to an aged care assessment;
- establish if the DSOA service coordinator has initiated a Change of Needs application and reviewed the DSOA older person's Individual Support Package prior to consideration of an aged care assessment; and
- establish that the DSOA older people understands the impacts on their DSOA funding should they proceed to assessment.

Aged care assessors should keep these policy settings in mind when making recommendations for aged care supports for a DSOA older person. That is, in making a recommendation, the aged care assessor needs to consider whether aged care services can appropriately support the older person were they to exit the DSOA Program.

Department of Health, Disability and Ageing website:

Disability Support for Older Australians Program (DSOA) manual

About the Disability Support for Older Australians Program

6.10.9. Carer support

Assessors should inform carers there is support and services specifically for them to access. This support is available through **Carer Gateway** and the National Dementia Helpline (for care partners of people with dementia or experiencing cognitive decline), both funded by the department.

Carer Gateway provides early-intervention and preventative supports and services to carers to help improve their well-being and long-term outcomes.

Carer Gateway is for all carers, no matter their age or the condition of the person they are caring for.

Carer Gateway consists of a website (www.carergateway.gov.au) and a national network of Carer Gateway service providers (CGSPs) (located in each state and territory).

CGSPs support carers with access to in person and digitally based supports and services including support planning, counselling, peer support, coaching, tailored support packages (including access to planned respite), emergency respite, and information and practical advice:

- Support Planning – assess the carer's needs and work with the carer to develop an agreed individual support plan.
- Counselling - professional counsellors for carers who are experiencing difficulties with anxiety, stress, depression and low mood as a result of their caring role.
- Peer Support – a service for carers to connect with people in similar caring circumstances and learning from their peers through the sharing of lived experiences.
- Coaching – carers work one to one with a coach, taking time to think about their own wellbeing and steps towards personal life goals.
- Tailored Support Packages – offers a range of practical supports to support carers access education and/or employment or assist carers in their caring role (e.g., access to planned respite, assistance with transport).
- Emergency Respite - help with accessing emergency respite support when a carer can no longer maintain the caring role due to illness for example.

CGSPs also assist with navigating relevant, local services available to carers, including My Aged Care, National Disability Insurance Scheme, Dementia Australia and referrals to other state/territory government funded carer support services.

CGSP staff talk with carers about the registration and support planning process and then work with them to provide access to supports and services based on their individual needs and caring circumstances. The intent of the support planning is for carers to have the most appropriate supports in place to help maintain their wellbeing, which in turn helps maintain their capacity to continue their caring role and also to participate in their communities.

Assessors should collect carer information in the My Aged Care Assessor Portal or Aged Care Assessor App and register the older person and their carer's consent to request a call back from Carer Gateway and/or the National Dementia Helpline. The carer's local CGSP and/or the National Dementia Helpline will then contact them to assist with accessing supports to help them in their caring role.

Alternatively, assessors may inform carers they can contact their local CGSP by calling 1800 422 737 (selecting Option 1), Monday to Friday, between 8am and 5pm, or by visiting the Carer Gateway website (www.carergateway.gov.au) and completing the online 'Request for Call Back' form.

The Carer Gateway website also provides carers with practical advice, information and resources to help them in their caring role, as well as access to:

- a national carer phone counselling service to help them manage daily challenges, reduce stress and strain, and plan for the future;
- an online peer support forum, connecting carers with other carers for knowledge and experience sharing, emotional support and mentoring;
- online self-guided coaching resources with simple techniques and strategies for goal-setting and future planning; and sources to increase skills and knowledge of carers relating to specific caring situations, to build confidence and improve wellbeing.

Assessors should also **note**, that CGSPs currently **do not** have the capability to receive referrals to book flexible, centre-based, cottage or residential respite for carers of My Aged Care older people.

Assessors should also be aware that under the Carer Gateway model, assistance for young carers to continue with or commence study through the Young Carer Bursary Program is available. Further information on the Young Carer Bursary Program and the application process is available at www.youngcarersnetwork.com.au/young-carer-bursary.

Dementia Australia's support for carers, family members, and representatives of people with dementia or experiencing cognitive decline includes providing in person, phone-based, or online dementia-specific counselling, peer support, and education.

Dementia Australia's carer supports can help people better understand the nature and impact of dementia, develop strategies to manage stress and mixed emotions, plan for the future, and manage grief.



Carer Gateway website

Carer Gateway service provider free call:1800 422 737

Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships

Young Carers Network website

For family, friends and carers | Dementia Australia

National Dementia Helpline: 1800 100 500 - 24 hours a day, 7 days a week

6.10.10. Aged Care Volunteers Visitors Scheme (ACVVS)

The Aged Care Volunteer Visitors Scheme (ACVVS) provides friendship and companionship to older people who are feeling lonely or socially isolated by matching them with a volunteer visitor. The ACVVS is a free program for eligible aged care recipients. Visits are available to anyone receiving Australian government-subsidised residential aged care or the Support at Home services. This includes care recipients approved or on the Support at Home Priority System and excludes those with a Commonwealth Home Support Program (CHSP).

The program requires the volunteer to make 20 ACVVS visits per year. These occur for approximately an hour a fortnight.

Anyone can refer an eligible older person to the ACVVS, including Aged Care Assessors, aged care service providers, health professionals, family members and friends. Older people can also refer themselves.

You can request a volunteer for an older person via the ACVVS website.



Aged Care Volunteer Visitors Scheme (ACVVS) | Australian Government Department of Health, Disability and Aged Care

6.10.11. Interpreting and translation services for people from culturally and linguistically diverse backgrounds

Every older person has a right to communicate in their preferred language or method of communication, with access to interpreters and communication aids as required.

If an older person requires an interpreter or translation services, it is the responsibility of the assessment organisation to access these services as needed to support the older person through the assessment process.

Sign language interpreting services

Older Australians who are deaf, deafblind or hard of hearing, who are seeking to access or are in receipt of Commonwealth funded aged care services can access **free** sign language interpreting and captioning services. Sign language services can be provided face-to-face or by Video Remote, and live captioning services are available to support older people to better engage and fully participate in their aged care journey and activities of daily living.

Information on how service providers can access interpreting services is available online at My Aged Care (or by calling 1800 200 422) or Deaf Connect (or by calling 1300 773 803).

If an older person enquires about sign language interpreting for daily activities, not aged care related, please refer them to Deaf Connect where they can also receive free services.

Sign language services are available in Auslan, American Sign Language, International Sign Language, and Signed English for Deaf or people who are hard of hearing, and tactile signing and hand over hand for people who are deafblind.

6.10.12. Interpreting services for Aboriginal and Torres Strait Islander people

It is important for older Aboriginal and Torres Strait Islander people accessing or thinking of accessing Australian Government-funded aged care services to be able to communicate in an Aboriginal and Torres Strait Islander language if that is their preference.

To access Interpreter Connect, an Aboriginal and Torres Strait Islander person should call My Aged Care on 1800 200 422 and ask for an interpreter from the following list of languages. Through the interpreter, My Aged Care will answer the person's aged care questions and then, if asked to, will assist them with accessing services. Languages available include:

- Alyawarre
- Anmatyerre
- Arrernte (Eastern and Central)
- Arrernte (Western)
- Djambarrpuyngu
- Gumatj
- Kriol (Top End)
- Murrinh Patha
- Ngaanyatjarra
- Ngaatjatjarra
- Pintupi-Luritja
- Pitjantjatjara
- Torres Strait Creole/Yumpla Tok
- Warlpiri
- Yankunytjatjara
- Yolngu Matha

If an interpreter from the above list is not available at the time of the call, an appropriate time that suits the Aboriginal and Torres Strait Islander person will be arranged. This service aims to make it easier for older Aboriginal and Torres Strait Islander people, their families and carers to access information on ageing and aged care, to have their needs assessed and to be supported to find the most appropriate services.

6.10.13. Elder Care Support

The Elder Care Support Program was established to recruit and train a trusted workforce to support older Aboriginal and Torres Strait Islander people and their families throughout their aged care journey. This support contributes to older people achieving a better, safer experience when accessing aged care services and having the information to make decisions on the care they need and receive.

The Elder Care Support program provides services that include:

- supporting older Aboriginal and Torres Strait Islander people to understand aged care services, navigate the assessment process and help with choosing a provider
- supporting families, friends and carers to understand how to access aged care services
- advocating for older Aboriginal and Torres Strait Islander people by working with assessors and providers to meet their needs
- supporting older Aboriginal and Torres Strait Islander people while they receive aged care services
- assisting with other types of health needs, such as disability supports.

The National Aboriginal Community Controlled Health Organisation (NACCHO) Aged Care Programs team can provide further information about the program at agedcare@naccho.org.au.



Elder Care Support

6.10.14. Care Finder Program

The care finder program offers tailored, intensive support to people who have one or more reasons for requiring assistance to interact with My Aged Care and access aged care services and other relevant community supports.

Care finders help vulnerable older people understand and access aged care and connect with other relevant supports in their community. This includes people who are, or are not yet, receiving aged care services or other relevant supports.

Care finders support people who don't have family, friends, a carer or any other person they are comfortable receiving help from and who is willing and able to help them access aged care services and supports. Care finders conduct outreach and then register the older person through the My Aged Care contact centre.

Primary Health Networks (PHNs) are responsible for commissioning and managing care finder services, leveraging their commissioning expertise and in-depth understanding of local community needs.

Contact information for care finder services in each region is on the My Aged Care website at Help from a care finder.



Care finder program

7. Chapter 7: Delegations and approvals under the Act

What you'll find in this chapter

This chapter includes information about:

- the powers under the *Aged Care Act 2024* that are delegated to triage delegates and clinical and non-Clinical assessment delegates.
- how approvals work under the *Aged Care Act* 2024, and the decisions that delegates make.

7.1. Delegation of powers and functions under the *Aged Care Act 2024*

Under section 339 of the *Aged Care Act 2024* (the Act), the System Governor plays a key role in the governance of the aged care system responsible for facilitating equitable access to funded aged care services. Section 7 of the Act specifies the position of the System Governor is occupied by the Secretary of the Department of Health, Disability and Ageing.

The System Governor has the power under section 567 of the Act to delegate their functions and powers to others who may exercise them on their behalf. The Instrument of Delegation outlines the specific functions, powers and responsibilities of the System Governor which are delegated to certain positions within assessment organisations. Staff who occupy these positions are considered delegates and will continue to be nominated through the on/off delegate form.

Delegations are tied to the position, not to the individual. This means that the powers and functions stay with the role, and any qualified person who has been approved to hold the position can exercise these powers. The Instrument of Delegation outlines which positions within each assessment organisation can hold these responsibilities.

These delegations operate within the Single Assessment System, and delegates must comply with Commonwealth guidelines, and any directions issued by the Secretary. This ensures that the delegation framework remains in line with current policies and standards.

7.2. Delegate responsibility

The role of the delegate is that of a primary decision-maker within a structured legal system. This means delegate decisions must be based on the legal requirements, facts, evidence, and clear reasoning. Understanding the legal framework and decision-making requirements is essential to making sound, defensible judgments.

The Single Assessment System relies on delegates to fulfil their role efficiently and effectively. Delegate decisions ensure that due process is followed and that eligible clients receive the care and support they need.

Decisions made by assessment delegates may be subject to review in various contexts. This could include reconsideration requests or formal reviews by bodies such as the Administrative Review Tribunal (ART).

As a result, it is important that delegates maintain accurate, complete records and clear justifications for every decision they make.

There are three delegate positions which sit within assessment organisations:

- Triage delegates
- Clinical assessment delegates
- Non-clinical assessment delegates

Under the *Aged Care Act 2024*, these delegate positions will be involved in certain assessment related activities outlined in the table below.

Table 33. Assessment related activities of delegate positions

Delegate position	Delegate activity
Triage Delegates	• Consider and determine an older person's eligibility for an aged care needs assessment or reassessment • Determine whether an older person requires a reassessment • Notify an older person of decisions and their right to review • Consider whether the older person requires access to urgent services
Non-clinical Assessment Delegate	• Approve an older person's eligibility to access aged care services under the Commonwealth Home Support Program • Limit or vary an older person's approval for funded aged care services • Notify an older person of decisions and their right to review • Consider and approve any appropriate changes to an older person's access approval for services under the CHSP as a result of a support plan review
Clinical Assessment Delegate	• Approve an older person's eligibility to access funded aged care services, including Urgent services through the CHSP • Limit or varying an older person's approval for funded aged care services • Approve extensions for transition care and residential respite care services • Notify an older person of decisions and their right to review • Consider and approve any appropriate changes to an older person's access approval for services as a result of a support plan review • Consider and determine the outcome of a classification reassessment



For information about how to assign individuals to delegate positions, see Chapter 13: Operating procedures.

7.3. Triage delegates

Triage delegates are delegated under the *Aged Care Act 2024* (the Act) to decide:

- under Section 58 of the Act, whether an older person is eligible for a needs assessment for government funded aged care services.
- under section 64 of the Act, whether an older person has undergone a significant change of circumstances or other change in their circumstances and requires a reassessment of their needs.

To find someone eligible for a needs assessment, a triage delegate must be satisfied the older person meets the age eligibility requirement and has declared they have an aged care need.

See Chapter 5: Assessment activities for information about the function of the triage delegate and conducting triage.

7.4. Assessment delegates

7.4.1. Non-clinical assessment delegates

Non-clinical Assessment Delegates are delegated the authority under the Act to approve entry-level services arising from a home support assessment.

- This means they can only approve access to the Commonwealth Home Support Program (CHSP).

- assistive technology (AT) and/or home modifications (HM) under CHSP (*not* under the AT-HM scheme).

If any approvals other than those listed above are required, the assessor must convert the assessment to a comprehensive assessment. Once an assessment is converted to a comprehensive assessment, the approval will flow to a Clinical Assessment Delegate. Clinical Assessment Delegate approval is required for all other approvals as outlined in detail in the next section.

All needs assessors will have the ability to apply for non-clinical assessment delegation under the *Aged Care Act 2024* (the Act) to approve entry-level services. Assessment organisations can determine whether to permit all needs assessors to perform this function.

A learner assessor must not be appointed a non-clinical delegate until they have completed all mandatory training requirements set out in the My Aged Care Workforce Learning Strategy and been issued with a completion certificate on MAClearning.

When approving the recommendations from an assessment they have undertaken, needs assessors, acting in their capacity as a non-clinical assessment delegate should exercise due care to ensure the assessment is complete, evidence based, free from errors, contradictions, or omissions.

7.4.2. Clinical assessment delegates

Clinical assessment delegates are delegated the authority under the Act to approve an older person for all service groups, classification types and classification levels.

> Note: Clinical Assessment Delegates can approve entry-level home support services (as non-clinical assessment delegates do) if assessment organisations have chosen to allocate home support assessments to clinical assessment delegates.

7.5. Overview of approvals under the *Aged Care Act 2024*

The *Aged Care Act 2024* (the Act) standardises the approval approach for funded aged care services, with all approvals given under the Act, using one service list which is divided into four Service Groups. This makes it more straightforward to give an older person a tailored package of care that meets their needs.

To be eligible for any funded aged care service an individual must first meet the criteria for an aged care needs assessment (as specified in Section 58 of the Act). Eligibility is now determined by a triage delegate, who holds relevant decision-making powers delegated by the System Governor.

Once determined as eligible, an aged care needs assessment is conducted to determine whether the older person requires funded aged care services. Based on this assessment, the assessor recommends funded aged care services they consider the individual needs to meet their care needs as well as any services, service types and service groups they consider the individual should be approved for under section 65 of the Act. It should be noted that under the same provision, older Aboriginal and Torres Strait Islander persons only need an approval at the service group level to receive aged care services. These recommendations are documented in a support plan, which is issued to an assessment delegate for consideration shortly after the assessment has been completed.

For an older person to start using funded aged care services, they need to be approved for the following under the Act:

1. **Service groups,** which specify the setting and nature of care an individual can access
2. **Classification types,** which specify the different time periods that services are delivered for under the service group.
3. **Service types** and **services** (for some older people, in some circumstances) – Service types are groups of different services. The services under these types are set out under the Aged Care Service list. Different service types sit under each service group. Older Aboriginal and Torres Strait Islander people only need an approval at the service group level ‑ they are automatically approved for all service types and services in that group.
4. **Classification levels,** which determine the amount of funding available to deliver funded aged care services to the individual. The individual receives a classification level for the classification type for the service group they have been approved to

access. The classification levels are specified in the Rules (see Division 3 Part 3 of Chapter 2 of the Rules).

5. **Priority categories** – determines priority for a classification type for a service group.

Note: individuals must be approved under the *Aged Care Act 2024* to access any funded aged care services, including if delivered through CHSP, MPSP and NATISFACP. This is a significant change as individuals could previously access services through these programs without approval under the *Aged Care Act 1997*.

7.6. Delegate decisions under the *Aged Care Act 2024*

Although assessors provide recommendations and supporting evidence via the assessment report (support plan), the final approval decision rests with the assessment delegate, except an ongoing home support classification level and assigning a priority level for Support at Home which are automated decisions.

While assessment delegates exercise the powers of the aged care System Governor, they remain personally accountable for the decisions they make under the *Aged Care Act 2024* (the Act). This underscores the significant responsibility of the Assessment Delegate role.

Once an aged care needs assessment is finalised, the assessment delegate must ensure that all eligibility requirements are met before approving any service group, service type, or specific funded aged care service. This means that the older person's situation must comply with the conditions outlined in sections 65-68 of the Act and any additional eligibility criteria set by the relevant rules must be satisfied. If these requirements are not met, the assessment delegate cannot approve the provision of aged care services.

7.6.1. Deciding if the older person requires aged care services

Assessment delegates must first determine whether the individual requires access to funded aged care services, and which service groups, and in some cases service types and services they require. This requirement is set out in section 65(2) of the Act.

This decision is made based on:

- An assessment report (referred to in practice as the support plan),
- In the case of reassessments in accordance with 64(1)(c)(ii) of the Act, any relevant information relating to the individual provided.

The table below summarises the sections of the Act that relate to eligibility for access to services. These sections of the Act, and how they apply to an assessment delegate's decision-making, are explained in detail in the following sections.

Table 34: Approval to access funded aged care services under section 65

Section criteria of the Act		Available service group/s	Available classification type/s	Relevant program/s
66	Individual must be an Aboriginal or Torres Strait Islander person The individual must meet any eligibility requirements prescribed by the rules for the relevant service group.	• Residential Care • Home Support • Assistive Technology • Home Modifications	All classification types	All programs.
67	Individual must have an impairment; **and** There must be a specific reason why the individual requires access to the service type/s or services. The individual must meet any eligibility requirements prescribed by the rules for the relevant service group.	• Home Support • Assistive Technology • Home modifications	All classification types	• Support at Home • CHSP • TCP • MPSP • NATSIFACP
68	Individual must have a continuing need for residential care because they are 'sick' The individual must meet the eligibility requirements prescribed by the rules for the service group residential care.	• Residential Care	All classification types	• Residential care (ongoing or short-term) • TCP • MPSP • NATSIFACP

Figure 7 below provides a visual summary of the three pathways to access approval (sections 66, 67 and 68).

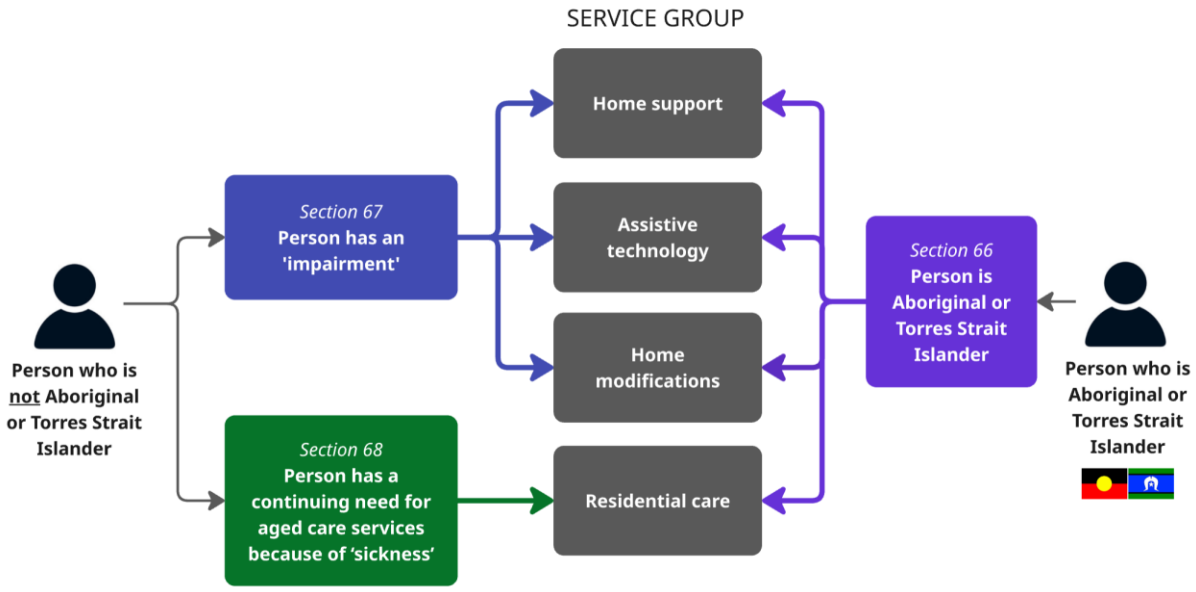


Figure 7 – Overview of pathways to approval for service access under the Act

7.6.2. Section 66 – Aboriginal or Torres Strait Islander persons

Section 66 provides a special pathway for Aboriginal or Torres Strait Islander people to be approved under section 65(1) to access funded aged care services. This pathway is unique for Aboriginal and Torres Strait Islander people because it relies on a different power in the Constitution to the other eligibility for approval provisions.

Under section 66, an older Aboriginal or Torres Strait Islander person can be approved under section 65(1) for any service group, which includes all of the service types and services in the group.

Figure 8 below gives an overview of the section 66 pathway to access approval for older people who are Aboriginal or Torres Strait Islander.

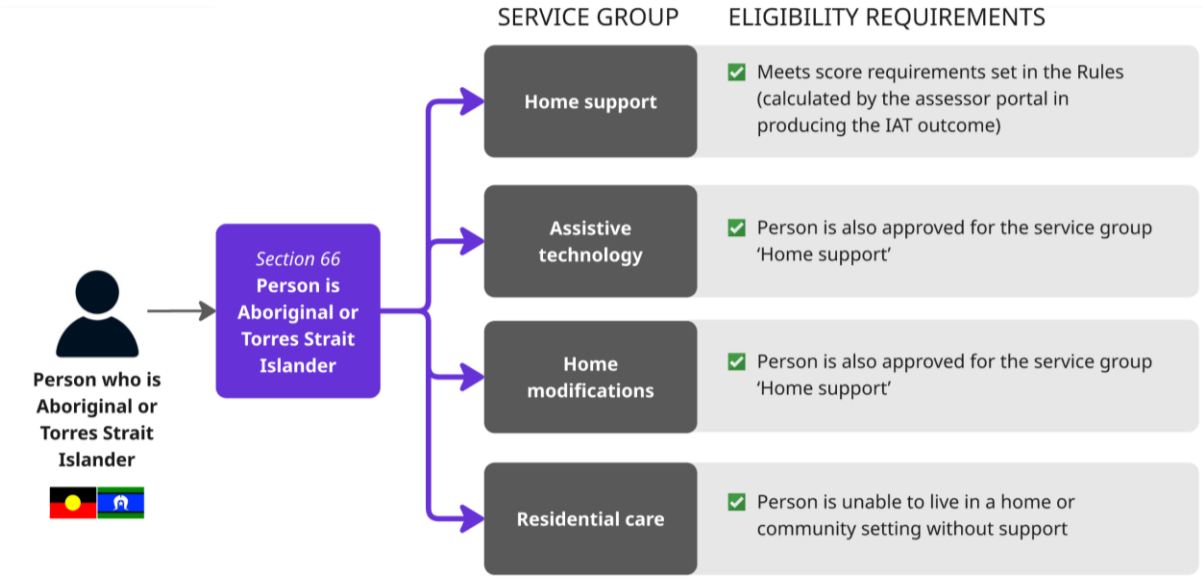


Figure 8 – Overview of section 66 pathway to approval for service access

Additional eligibility requirements

While an older Aboriginal or Torres Strait Islander person can be approved at the service group level for any service group, delegates will still need to take into account the additional eligibility requirements in the *Aged Care Rules 2025* (the Rules) for the service group (or groups) the person is actually approved for (section 65-10 to section 65-20 of the Rules). This is required because of section 65(3) of the *Aged Care Act 2024*.

The additional requirements for each service group are set out below.

Additional eligibility requirements for home support

The system will calculate the score necessary to determine whether an older person has met the additional eligibility requirements for the home support service group listed below. This calculation is made by drawing on the responses from within the Integrated Assessment Tool (IAT). The role of an assessment delegate is to ensure information is accurately recorded in the IAT and to have consideration for the legislative eligibility criteria even though the score is calculated by the system.

The additional requirements for the home support service group are that the person meets any of the 'score' requirements for the particular questions in the IAT. These are outlined in the table below.

Table 35. Additional eligibility requirements for the home support service group under section 66

A person has a total score of less than 20 for the questions in the IAT with the following headings:	• Climb stairs • Eating • Dressing • Take a bath or shower • Grooming • Transfers • Toilet use • Toileting – bladder • Toileting – bowels • Walk
OR	
The person has a total score of less than 14 for the questions in the IAT with the following headings:	• Get to places out of walking distance • Undertake housework (heavy/moderate) • Go shopping (assuming transportation) • Prepare meals • Take medicine • Handle money • Use the telephone
OR	
The person has a score greater than zero for the questions in the sections of the IAT headed:	• Cognition • Medical and Medications
OR	
The individual has a score greater than zero for questions in the section of the IAT headed:	• Psychological
OR	
The individual has a score greater than zero for the questions in the section of the IAT headed:	• Physical, Personal Health or Frailty

Additional eligibility requirements for assistive technology and home modifications

- the individual is also approved for the home support service group.

Additional eligibility requirements for residential care

- the individual is incapable of living in home or community setting without support.

7.6.3. Section 67 – a person who has an impairment or sickness

Section 67 is the pathway for non- Aboriginal or Torres Strait Islander people to be approved under section 65(1) for the following service groups:

- home support
- assistive technology
- home modifications.

There are special requirements for approving a person where section 67 applies to them, because of the legal basis in the Constitution that supports the approvals.

When approving a person for service types or particular government-funded aged care services because section 67 applies to them, it is not possible to approve them at the service group level. Assessment Delegates will need to select and decide the particular service type/s the older person requires, or for particular service types the individual service/s (further information below). This is a necessary legal requirement because of the constitutional powers that support the provision of these types of services under the *Aged Care Act 2024 (the Act)*.

Figure 9 below gives an overview of the section 67 pathway to access approval.

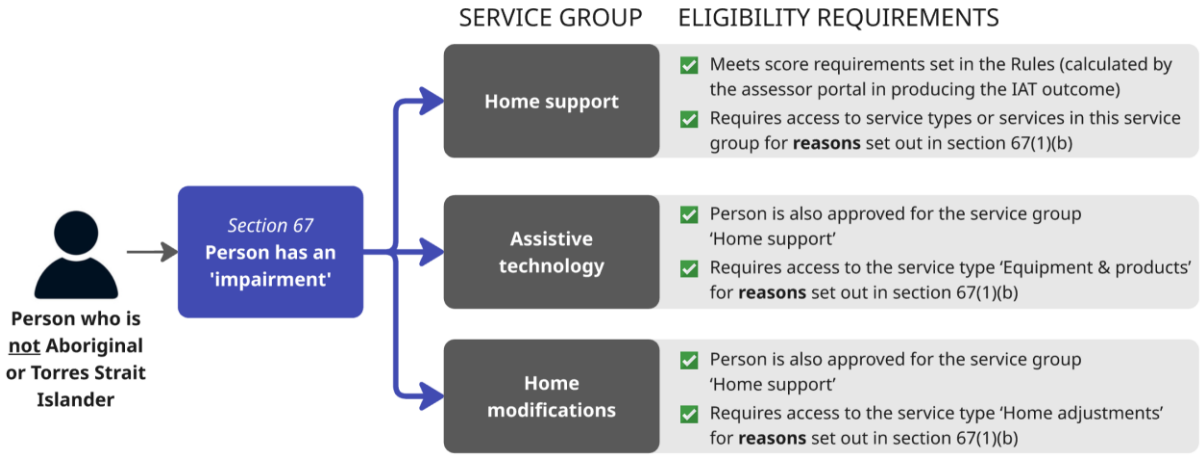


Figure 9 – Overview of section 67 pathway to approval for service access

Deciding if the person should be approved

When deciding if an older person should be approved for the Home Support, Assistive Technology or Home Modifications service group/s under section 65 of the Act where section 67 applies to them, assessment delegates will need to take the following steps:

1. Assessment delegates must be satisfied that the older person has a disability or an "impairment"

    a. the impairment must be long-term and be a physical, mental, sensory or intellectual impairment, and

    b. because of its interaction with various barriers, the impairment may hinder the person's participation in society on an equal basis with others.

2. Decide which service types the older person requires access to.

    a. For the service types 'Allied health and therapy' and 'Therapeutic services for independent living' an assessment delegate must also decide which individual services in those service types they require access to.

3. Assessment delegates must then be satisfied that there is a specific reason why the person requires access to the service types (or the particular funded aged care services – see step 2a.). These reasons are set out in section 67(1)(b) of the Act and explained further below.

4. Assessment delegates must also be satisfied that the person meets the additional eligibility criteria in the Rules. These criteria are outlined below.

Impairment

Information about the person's "impairment" will already be reflected in the information collected using the Integrated Assessment Tool (IAT) and any other relevant information gathered during the assessment, such as information from the person's GP or other health records. For the purposes of recording the approval decision, an assessment delegate will need to be satisfied the information provided identifies the long-term impairment (or impairments) that the older person has. This should be evident from the assessment information.

It should also be evident from the assessment/IAT/Support Plan information the barriers the person faces to their independence because of their impairment and how this impacts their ability to participate and be included in the community.

EXAMPLE 1

The older person may be physically impaired because of a musculoskeletal disorder or be vision impaired, which was identified through their assessment and recorded in the IAT, or evidenced in a record or report for the person provided by a GP or other health professional. This may impact, among other things, their functional ability and be recorded under the Function section of the IAT.

EXAMPLE 2

The older person may have a diagnosis of a pre-existing condition, such as arthritis or another physical or neurological condition, such as dementia or Motor neurone disease, as identified through their assessment in the IAT. This may be recorded as a health condition under the Medical and medications section.

For both above examples, the older person's condition may impact their ability to participate in the community, as they would require support to enable them to continue living at home and maintain their independence.

Special requirements for 'Allied health and therapy' and 'Therapeutic services for independent living'

When approving an older person for the service types 'Allied health and therapy' and 'Therapeutic services for independent living,' assessment delegates will need to consider which individual service (or services) in the service type the person requires access to because of their needs.

This is because each funded aged care service that is considered an allied health, therapy or other therapeutic service is directed at a different physical, functional or cognitive issue – it's not possible to determine that a person with disabilities requires access to allied health or therapeutic services *generally* without considering if each particular service is required. This is an essential requirement because of the changes to the legal basis supporting the *Aged Care Act 2024* (the Act).

Specific reason/s why access is needed under Section 67

The Act requires Assessment Delegates to consider reasons why an older person needs access to the service types or particular services. Assessment Delegates must turn their minds to these reasons when deciding on the service types/services.

The reasons are that the service type (or service(s) within the service types of *Allied health and therapy* and *Therapeutic services for independent living*):

i. is an in-home, residential or community support service that is necessary to support the person to live and be included in the community and prevent them from being isolated or segregated from their community

ii. will facilitate personal mobility of the person in a way that the individual chooses

iii. involves a mobility device or equipment, or assistive technology, that will facilitate personal mobility

iv. is a health service that the person needs because of their impairment or because of the impairment and the interaction with various barriers

v. is a habilitation or rehabilitation service

vi. is a service that will assist the person to access any of the services they need because of any of the reasons above

vii. will minimise the prospects of the person, or prevent the person from, acquiring a further impairment

viii. is a medical service required by the person because of sickness.

For ease of understanding, these have been re-framed as needs of the older person in the table below (this is how they appear in the Notice of Decision).

Table 36. Reframed reasons for access under section 67

It has also been determined that you require access to the stated service types and/or services because you …
need support to live and be included in your community
need support with your mobility
need support to reduce the chances of you becoming more impaired
need health services because of your impairment
need support to regain skills and abilities or learn new ones
need help to access services for which you've been approved

When making a decision, assessment delegates must consider the older person's circumstances overall and what service types and services they need, and for what reason. This should already be evident from the information recorded in the Integrated Assessment Tool (IAT) or the support plan, which detail what the person's needs are, and why the person needs support and what help they need.

Potential applicable reasons for service types/services are set out in the table below.

Table 37. Service types/services and potential applicable reasons under section 67

Reason	Reason may apply when approving the older person for…
1. Need support to live and be included in your community	• any service type **except** 'Nursing care' from the service group 'home support' (including services accessed through TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme, CHSP or TCP
2. Need support with your mobility	• the service type 'Transport' from the service group 'home support' (included in any approval for TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme or CHSP
3. Need support to reduce the chances of you becoming more impaired	• the service type 'Assistance with transition care' (part of any approval for TCP) • 'Equipment and products' or 'Home adjustments' under the AT-HM Scheme or CHSP
4. Need health services because of your impairment	• The service type 'Allied health and therapy'[4] • The service type 'Nursing care' • The service type 'Therapeutic services for independent living'[5] • *Note that all of the above may be accessed through TCP*
5. Need support to regain skills and abilities or learn new ones	• the service type 'Assistance with transition care' (part of any approval for TCP)

[4] Remembering that for this service type you will need to decide the individual service (or services) the older person needs and turn your mind to the reason why they need that particular service (or services).
[5] Remembering that for this service type you will need to decide the individual service (or services) the older person needs and turn your mind to the reason why they need that particular service (or services).

Reason	Reason may apply when approving the older person for…
6. Need help to access services for which you've been approved	• 'Equipment and products' under the AT-HM Scheme or CHSP • The service type 'Restorative care management' under the service group 'home support' (e.g. Restorative Care Pathway) • the service type 'Assistance with transition care' (part of any approval for TCP)

Once an Assessment Delegate has considered which service types are needed and why, they need to record the reasons for their decision in the Notice of Decision. Assessment Delegates will be required to delete the reasons which they consider do not apply from the list of reasons above.

Health services - examples

An example of a health service is physiotherapy or other services delivered by a registered health professional.

An example of approving access to a service because it is a 'health service' required 'because of the individual's impairment' could be approving them for the service 'Physiotherapy' in the 'Allied health and therapy service type.' This is because the physiotherapy is required to support them with managing their diagnosis of Motor Neuron disease.

Habilitation and rehabilitation services - examples

Allied health services such as occupational therapy or physiotherapy are examples of habilitation or rehabilitation services.

An example of approving access to a service because it is a 'habilitation or rehabilitation service' could be approving them for 'Acupuncture' in the 'Therapeutic services for independent living' service type, to support them in rehabilitation following a stroke.

Additional eligibility requirements

When approving a person under section 65(1) because section 67 applies to them, Assessment Delegates will also need to turn their mind to the additional eligibility requirements in the *Aged Care Rules 2025* for the service groups the person is actually approved for. This is required because of section 65(3) of the *Aged Care Act 2024*.

The additional requirements for each service group are set out below.

Additional requirements for home support

The system will do the work in calculating the score necessary to determine whether an older person has met the additional eligibility requirements for the home support service group listed below. This calculation is made by drawing on the responses from within the Integrated Assessment Tool (IAT). The Assessment Delegate is to ensure information is accurately recorded in the IAT and that you have consideration for legislative eligibility criteria even though the score is calculated by the system.

The additional requirements for the home support service group are that the person meets any of the 'score' requirements for the particular questions in the IAT, outlined in the table below.

Table 38. Additional eligibility requirements for the home support service group under the Rules

A person has a total score of less than 20 for the questions in the IAT with the following headings:	• Climb stairs • Eating • Dressing • Take a bath or shower • Grooming • Transfers • Toilet use • Toileting – bladder • Toileting – bowels • Walk
OR	
The person has a total score of less than 14 for the questions in the IAT with the following headings:	• Get to places out of walking distance • Undertake housework (heavy/moderate) • Go shopping (assuming transportation) • Prepare meals • Take medicine • Handle money • Use the telephone
OR	
The person has a score greater than zero for the questions in the sections of the IAT headed:	• Cognition • Medical and Medications
OR	

The individual has a score greater than zero for questions in the section of the IAT headed:	• Psychological
OR	
The individual has a score greater than zero for the questions in the section of the IAT headed:	• Physical, Personal Health or Frailty

Additional requirements for assistive technology and home modifications:

- the individual is also approved for the home support service group.

7.6.4. Section 68 – 'individuals with a sickness'

Section 68 is the pathway for non Aboriginal or Torres Strait Islander people to be approved under section 65(1) for funded aged care services in residential care.

This covers the residential care service group which includes both permanent (ongoing) and respite (short-term) residential care. It also covers older people who will access funded aged care services through the residential care service group under the Transition Care Program (TCP).

Approving a person for the residential care service group because section 68 applies to them will automatically approve them for all residential care service types, including the services under those types.

Figure 10 below gives an overview of the section 68 pathway to approval to access the residential care service group.

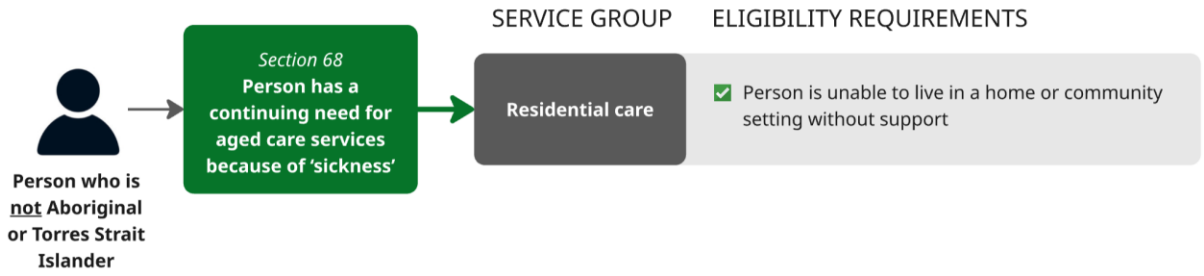


Figure 10– Overview of section 68 pathway to access approval for residential care

Deciding if the person should be approved

When approving an older person for the residential care service group, Assessment Delegates will need to be satisfied that:

1. the person is "sick," and
2. Because of their "sickness," they have a continuing need for residential care services, including nursing services.
3. The person meets the additional eligibility criteria in the Rules. These criteria are outlined below.

Sickness

"Sickness" for the purposes of the *Aged Care Act 2024* (the Act) means an infirmity, illness, disease, incapacity or impairment. Sickness can be a strictly physical illness, such as a heart condition but will also encompass mental health conditions like depression or anxiety, or neurological disorders, such as dementia.

Information about the person and their "sickness" will already be reflected in the information collected using the Integrated Assessment Tool and any other relevant information gathered during the assessment, such as information from the person's GP or other health records. For the purposes of recording the approval decision Assessment Delegates will need to be satisfied the information provided identifies that the older person is "sick" and because of that they have a continuing need for residential care, including nursing services. This is a necessary legal requirement because of the constitutional powers that support the provision of residential care under the Act.

The requirement that the person is sick and has a "continuing need" for residential care "including nursing services" applies in the same way to respite care (short-term) and Transition Care (hospital transition) as it does to permanent (ongoing) residential care. While the person will only be approved to access care for a limited period of time if they are approved for respite or Transition Care, Assessment Delegates will still need to be satisfied they at the time of the assessment that they have a continuing need for residential care including nursing services due to their sickness.

Additional eligibility requirements

When approving a person for the residential care service group because section 68 applies to them, Assessment Delegates will also need to turn their mind to the additional eligibility requirement in the Rules. This is required because of section 65(3) of the Act.

The additional requirement is:

- the person is incapable of living in a home or community setting without support.

7.7. Approvals for service groups, classification types and classification levels

The foundational building blocks of approvals under the *Aged Care Act 2024 (*the Act) are service groups, classification types and classification levels.

- Service groups specify the setting and nature of care an individual can access. There are four service groups: home support, assistive technology, home modifications and residential care.
- Classification types differentiate the time period that services are delivered for under the service group. There are three classification types: ongoing, short-term and hospital transition. Each classification type has a different purpose in meeting the needs of an individual and so are funded and timed accordingly.
- Classification levels determine the amount of funding available to deliver the aged care services that an individual has been approved to access under a service group.

Under the Act, approvals for a service group, a classification type and a classification level combine to create something that is comparable to an approval for a program under the *Aged Care Act 1997*.

The table below compares some examples before and after the introduction of the Act.

Table 39. Comparison of approvals under the Aged Care Act 1997 and Act Care Act 2024

Before the introduction of the *Aged Care Act 2024*	**After the introduction of the *Aged Care Act 2024*, the older person is approved for⋯**
Home Care Package Level (1-4)	**Service group:** Home support **Classification type:** Ongoing **Classification level:** SAH (Support at Home) Class (1-8)
Commonwealth Home Support Program (CHSP)	**Service group:** Home support **Classification type:** Ongoing **Classification level:** CHSP Class
Residential respite care	**Service group:** Residential care **Classification type:** Short-term **Classification level:** Respite Class (1-3)
Short-term Restorative Care Programme	**Service group:** Home support **Classification type:** Short-term **Classification level:** SAH Restorative Care Pathway

The following sections show the possible combinations of classification type and classification level a person can be approved for under each service group.

Decisions for service group and classification type are made under section 65(2) of the Act. Decisions for classification level are made under section 78 of the Act.

7.7.1. Service group: Home support

Table 40. Possible combinations of classification type and classification level under the service group of home support

Service group	Classification type	Classification level
Home Support	**Ongoing**	CHSP class Support at Home (SAH) class 1 to 8
	Short-term	SAH restorative care pathway SAH end-of-life pathway
	Hospital transition	Home Support Hospital Transition class (HS HT class)

7.7.2. Service group: Assistive technology

Table 41. Possible combinations of classification type and classification level under the service group of assistive technology

Service group	Classification type	Classification level
Assistive technology	**Ongoing**	assistance dogs
	Short-term	AT CHSP AT low AT medium AT high
	Hospital transition	AT HT class

Note that classification levels are also referred to as ‘funding tiers’ in the Support at Home program.

7.7.3. Service group: Home modifications

Table 42. Possible combinations of classification type and classification level under the service group of home modifications

Service group	Classification type	Classification level
Home modifications	**Short-term**	HM CHSP HM low HM medium HM high

Note that classification levels are also referred to as 'funding tiers' in the Support at Home program.

7.7.4. Service group: Residential care

Table 43. Possible combinations of classification type and classification level under the service group of residential care

Service group	Classification type	Classification level
Residential Care	**Ongoing**	Class 0 Class 1 to Class 13
	Short-term	Class 0 Respite class 1 to Respite class 3
	Hospital transition	RC HT class

Note that 'Class 0' is a default classification applied before the client has been assessed for their classification level.

7.8. Approvals for service types and services

The Aged Care Service List is defined in the *Aged Care Rules 2025*. It lists the four service groups, and the service types and services within them.

> Important:
>
> For an Aboriginal or Torres Strait Islander person, an Assessment Delegate only needs to approve them for one or more service groups. They are automatically approved for all the service types and services in any service group they are approved for.

If the older person is not an Aboriginal or Torres Strait Islander person, and an Assessment Delegate is approving the Home Support, Assistive Technology or Home Modifications service groups, they must decide:

- which **service types** to approve within each service group
- which **services** to approve, but **only if they are being approved for the following 'prescribed' service types**: *Allied health and Therapy* and *Therapeutic Services for Independent Living.*

> Note:
>
> If an Assessment Delegate is approving an older person for any service type other than the 'prescribed' service types (Allied health and Therapy and Therapeutic Services for Independent Living), they are also approved for all services in that service type.

Any older person approved for the residential care service group is automatically approved for **all service types and services in that service group.** Section 65(2) of the Act has more information about these requirements.

7.9. Approvals for priority categories

Priority categories are assigned to individuals (under section 86 of the *Aged Care Act 2024* (the Act)) to determine when certain services are allocated under section 92 of the Act. These categories are based on the assessed urgency of need, complexity of care requirements and potential risks associated with delayed support.

The Assessment Delegate does not make decisions on priority category under the Act. Priority categories are assigned by the system (assessor portal). However, Assessment Delegates are responsible for ensuring the correct information is used to calculate any priority category and communicating any priority category decision to the older person.

Priority categories are required to be assigned for an individual for the following service groups and classification types:

- Home support – ongoing (excluding CHSP class)
- Assistive technology – ongoing and short-term
- Home modifications – short-term
- Residential care – ongoing

In practice, this looks like the following:

1. The aged care needs assessment is carried out.
2. A priority category is calculated and assigned by the system (**not** the assessor) at the end of an assessment. In some cases, there is only one applicable priority category.
3. The assessment delegate confirms the information that has been used to calculate the priority category.
4. The priority category is pre-populated into the Notice of Decision (the assessment outcome letter).

Approvals for Transition Care, End-of-Life Pathway, Restorative Care Pathway, short-term residential care (respite care), and CHSP class do not require a priority category. The Notice of Decision template marks the priority category for these as 'N/A,' you should leave these fields unchanged.

The below table summarises the service groups, classification types, classification levels, and priority categories covered in this section.

Table 44. Priority categories for service groups, classification types and classification levels

Service group	Classification type	Classification level *Referred to as 'funding tiers' for AT and HM*	Priority category
Home support	Ongoing	SAH class 1 SAH class 8	Urgent, High, Medium, Standard
	Ongoing	CHSP class	N/A
	Short-term	SAH restorative care pathway SAH end-of-life pathway	N/A
	Hospital transition	HS HT class	N/A
Assistive technology	Ongoing	assistance dogs	High, Medium, Standard
	Short-term	AT low AT medium AT high	High, Medium, Standard
		AT CHSP	Immediate
	Hospital transition	AT HT class	N/A
Home modifications	Short-term	HM low HM medium HM high	High, Medium, Standard
		HM CHSP	Immediate
Residential care	Ongoing	Class 0 (pre AN-ACC assessment) Class 1 to Class 13	Priority One, Priority Two, Priority Three

Service group	Classification type	Classification level *Referred to as 'funding tiers' for AT and HM*	Priority category
	Short-term	Class 0 (pre AN-ACC assessment) Respite class 1 to Respite class 3	N/A
	Hospital transition	RC HT class	N/A

7.9.1. Home support – ongoing

The priority category for ongoing Support at Home is assigned by the prioritisation algorithm using seven criteria captured in the Integrated Assessment Tool (IAT) or on the client's record. These are whether the older person:

1. lives alone
2. identifies as Aboriginal or Torres Strait Islander
3. has an assessed cognitive impairment
4. is experiencing homelessness or is at risk of homelessness
5. requires urgent service provision
6. has waited more than six months from the initial assessment referral and lives in a regional or remote area categorised under MMM 5-7
7. has Motor Neurone Disease (MND).

7.9.2. AT-HM scheme

The priority categories for AT-HM are calculated based on 5 different criteria captured in the Integrated Assessment Tool (IAT) or on the client record. These are whether the person:

1. lives alone
2. has an assessed moderate or severe mobility impairment
3. identifies as Aboriginal or Torres Strait Islander person
4. current place of residence poses a moderate to severe risk to their health or safety
5. has waited more than six months from the initial assessment referral and lives in a regional or remote area categorised under MMM 5-7.

Further information is available in the AT-HM scheme guidelines.

The priority category for all ongoing CHSP services will be 'Not applicable.'

7.9.3. Residential care

The priority category for Residential Care is calculated based on 5 different criteria captured in the IAT or on the client's record. The criteria is the older person/'s:

1. identifies as Aboriginal or Torres Strait Islander
2. is experiencing homelessness
3. resides in a rural or remote area (MMM 5 - 7)
4. has entered residential care through emergency circumstances
5. Urgency rating for residential care

7.10. Period of effect of approvals

Each access approval, classification level, and priority category has a period of effect that is prescribed under the *Aged Care Act 2024* (the Act). This means that access approvals remain in effect for the period of time specified by the Act unless the approval is revoked or a reassessment occurs resulting in a new approval.

In addition to the other legislative requirements, for an older person to receive funded aged care services they need both:

- An access approval that is in effect (or 'active') and
- A classification level that is in effect

Periods of effect for an approval decision made by Assessment Delegates are detailed in sections 71, 80 and 89 of the Act.

7.10.1. Period of effect of access approvals

When an individual is approved for access to funded aged care services 65(2) of the *Aged Care Act 2024* (the Act), the approval takes effect from the access approval date of effect specified in the Notice of Decision (as outlined in Section 70). The approval stays in effect unless it is revoked under the Act or replaced by a new decision.

7.10.2. Period of effect of classification levels

Classification levels are in effect for the period specified in the *Aged Care Rules 2025* (the Rules). Once the specified period has elapsed, the classification level will cease to be in effect. A classification may also cease to be in effect once another classification level comes in effect.

Written notice must be provided to an individual in accordance with section 79 of the Act which specifies the day when each classification level comes into effect. For individuals approved for the service groups home support, assistive technology or home modifications this notice is usually included in the Notice of Decision provided under section 70 of the Act.

Some classification levels, such as *CHSP class*, come into effect on the access approval date of effect. Others, such as the residential care classification levels, do not come into effect until the service provider notifies Services Australia that service has commenced.

The Rules also prescribe that, for some classification levels, the maximum period of effect may be extended. The criteria and requirements for granting such extensions are prescribed within the rules under the Act.

7.10.3. Period of effect of priority categories

A priority category for a classification type for a service group determines the level of priority for accessing those services.

An individual's priority category for a classification type for a service group takes effect immediately from when the prioritisation decision is made and remains in effect until either:

- The individual is allocated a place for that classification type and service group (under section 92), or
- A new priority category decision is made for that classification type for that service group following a reassessment of the individual (as per subsection 86(1) and paragraph 61(1)(b)).

7.11. Reassessment of a classification level

Depending on the classification type for service group, an individual or a registered provider acting on behalf of the individual may have the right to apply for a reassessment of a classification level under section 82. Section 82 of the Act outlines who may apply for a classification assessment for each classification type for a service group and when an application may be made. This is outlined in the table below.

Table 45. Circumstances when a classification reassessment can be sought

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
Ongoing or short-term for home support, assistive technology or home modifications	The individual	If: • the classification type is in effect for the individual; and • the individual considers a different classification level in the classification type for the service group should be approved; and • the funded aged care services are not being delivered under a specialist aged care program; and • you consider the circumstances (if any) prescribed by the rules apply.
Ongoing for residential care	The individual A registered provider on behalf of	If: • The registered provider is delivering ongoing funded aged care services to the individual through the service group in an approved residential care home; and • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
	the individual	• the funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: o if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(2) of the Act in that time period; o you consider the circumstances (if any) prescribed by the rules apply.
Short-term for residential care	The individual The registered provider on behalf of the individual	If: • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • an access approval is in effect for the individual for the classification type for the service group; and • if the application is made by the registered provider: o the registered provider is delivering short-term funded aged care services through the residential care service group to the individual in an approved residential care home; and o those funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: o if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(3) of the Act in that time period; o You consider the circumstances (if any) prescribed by the rules apply.
Hospital transition (for any service group)	A registered provider on behalf of an individual	All of the following apply: • the registered provider is delivering hospital transition funded aged care services to the individual through the service group; and • the registered provider or the individual considers that an extension of the period of effect for the classification level that is in effect for the individual

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
		for the classification type for the service group should be approved for the individual.

When a reassessment is needed (for all classifications except those for the residential care service group), triage delegates will review the application, considering the individual's current care needs and whether they still meet the requirements for a classification reassessment.

If the application meets the necessary criteria, a reassessment will be carried out, and a new recommendation will be prepared and presented to the assessment delegate. Assessment delegates are responsible for deciding whether to approve a different classification level for the classification type for a service group or an extension of the classification level (if relevant) under section 78 of the *Aged Care Act 2024* (the Act). All new decisions must be documented in a new Notice of Decision letter which must be made in accordance with the requirements of section 79 of the Act**.**

Note that a classification reassessment for ongoing residential care is commonly known as an AN-ACC reclassification and is the responsibility of Residential Aged Care funding assessors.

7.12. Summary of assessment delegate responsibilities under the Act

The table below summarises all of the decisions that assessment delegates are empowered to make or actions they are empowered to take under the Act, assessment delegate responsibilities include notifying the older person (and their registered supporter/s, if applicable) of the outcome of their assessment; this is explained in detail in the following chapter.

Table 46. Summary of decisions and actions Assessment Delegates are empowered to undertake

Decision Type	Section	Decision/Action
Access Approval Decisions	65(1)	An assessment delegate receives and considers an individual's support plan, deciding whether the individual requires access to funded services

Decision Type	Section	Decision/Action
	65(2)	An assessment delegate must decide whether to approve one or more service groups and the classification types for the service groups In making this decision, the assessment delegate must be satisfied that all the requirements prescribed in s 65(3) is met.
	65(2)	If the service group is home support, assistive technology or home modifications and the individual is not an Aboriginal and Torres Strait Islander person, an assessment delegate must decide: • Whether to approve one or more service types in that group • If the service type is allied health therapy or therapeutic services for independent living whether to approve one or more funded services in that type
	65(4)	In exceptional circumstances an assessment delegate can approve access for an individual who has not undergone an assessment if: • The assessment delegate is satisfied exceptional circumstances apply that justify making the decision without an assessment. • An individual, or a registered provider on behalf of the individual, makes an application in an approved for. • Any circumstances prescribed by the rules do not apply.
	70(1)	The assessment delegate must give written notice of a decision under subsection 65(1) or (2) to the individual within 14 days after the decision is made
	71(2)	The access approval date (which is specified in the notice of decision) may be a date earlier than the access approval/notice is given. This can occur if you (as the assessment delegate), are satisfied than an individual: • needed urgent access to funded services and there was a significant risk of harm if services were not provided before an approval was given; or • is an Aboriginal or Tores Strait Islander person and at the time they were seeking services there was a lack of available assessors to undertake a culturally safe assessment; or

Decision Type	Section	Decision/Action
		• commenced receiving services through a specialist program before an approval was given and at the time the individual was seeking services there was a delay in the availability of a needs assessor It is also necessary that the criteria under s71(2) is met.
Classification Decision	78(1)	An assessment delegate must approve a classification level for the classification type and service group they have approved for the individual. The classification level decision for ongoing home support (i.e., CHSP or Support at Home 1-8) is an automated decision and is determined by the ongoing home support classification algorithm.
	79(1)	Section 79(1) requires than individual is given written notice of a classification decision made under section 78 for the individual within 14 days after the decision is made. The notice must comply with the requirements set out in s 79(2) and (3).
	80	Section 80 prescribes the period of effect for a classification level that has been established under section 78, with the maximum period of effect being prescribed under the Rules. The Rules also allow for a registered provider to apply for an extension to the maximum period of effect. The assessment delegate must consider the application and decide if a longer period should apply. Extensions can be sought for a classification level or the classification type hospital transition for the following service groups: • Home support • Assistive technology • Residential care One or more additional periods, together totalling not more than 42 days, for the classification level for the individual may be granted if the assessment delegate is satisfied that the individual requires access to funded aged care services for that level for the additional periods. The Rules also allow a registered provider to apply for an increase in the number of days for the classification level for the classification type short-term for the service group

Decision Type	Section	Decision/Action
		residential care, classification type short-term. An assessment delegate must consider the application and decide whether to approve an additional 21 days for the classification level. The assessment may delegate (you) may increase the number of days where you are satisfied it is necessary because of any of the following: • Carer stress • Severity of the older person's condition • Absence of the older person's carer • Any other relevant matter
Registration and cancellation of a supporter	37(1)	A decision to register a person as a supporter of an older person seeking or receiving aged care services. For Assessment Delegates, this responsibility does not include the registration of a person as a supporter without the consent of the older person, nor where the prospective supporter has declared a conflict or there is anything else to suggest they may not be able to comply with the supporter duties (e.g., the prospective supporter is currently suspended or had a previous supporter relationship cancelled). In these circumstances, the Assessment Delegate should progress the request to register the supporter relationship to the departmental delegate team responsible for supporters.
	37(7)	The assessment delegate may make a registration under section 37(1), in the circumstances described, verbally or in writing.
	52	Cancellation of a supporter's registration upon request of the registered supporter. This applies to supporter, supporter lite and supporter guardian relationships.
	53(1)(a)	Cancellation of a supporter's registration upon request of the older person, where the registered supporter is not also an active, appointed decision maker for the older person (that is, a person captured by section 28(2)) – meaning it is **not** a supporter guardian relationship).

8. Chapter 8: Delegate decisions in practice

What you'll find in this chapter:

This chapter includes guidance for assessment delegates covering:

- how to make sound, evidence-based decisions
- step-by-step processes for approving aged care services across the service groups
- other approvals (including giving approvals after a service has commenced and approving a service without an assessment).

8.1. Decision-making fundamentals

Effective decision-making requires sound judgment, evidence-based reasoning, and a commitment to fairness and accountability.

8.1.1. Essentials of good decision-making

Delegates need to exercise independent judgment when determining whether an individual is eligible to be approved for funded aged care services. Delegate decisions must be based on all relevant information obtained through the assessment process. Delegates are considered to possess the necessary skills and expertise to fulfil this delegated role with honesty, integrity and accuracy.

To minimise the risk of errors and ensure consistency in decision-making, Delegates should adhere to the following key principles:

- **Identify all material facts:** Delegates must establish all material facts that are essential to the decision. Only facts supported by reliable evidence should be taken into account.
- **Base decisions on evidence:** Avoid making decisions based on unsubstantiated facts. Every finding must be backed by relevant and logical evidence that clearly supports the conclusions.
- **Ensure reasonable judgement:** Delegate decisions must be reasonable and not be based on findings that are manifestly unreasonable. This means that the conclusions should be rational, defensible, and clearly justifiable.
- **Observe natural justice:** Delegates must respect the principles of natural justice throughout the decision-making process. In essence, this means ensuring that individuals are given a fair opportunity to explain their circumstances before a decision is made.
- **Comply with legal requirements:** Delegates must comply with any statutory obligations, including understanding the important new eligibility criteria for approvals and the requirement to provide a written statement of reasons when necessary.

8.1.2. Best practice guides for decision-making

To support delegates in this role, the Administrative Review Council (ARC) has developed a series of Best Practice Guides. These guides serve as both a training resource and a reference tool for primary decision-makers in Commonwealth agencies, including Delegates. They cover key aspects of decision-making and provide practical guidance to help you make sound, evidence-based decisions.

You can refer to the five ARC Best Practice Guides on the Attorney-General's Department website.



ARC Best Practice Guides : Administrative Review Council publications | Attorney-General's Department

Note: The Administrative Review Council (ARC) published the Best Practice Guides prior to 2015. While they continue to be regarded as sound policy, it is important to note that they have not been updated to reflect any changes in case law or relevant legislation since their publication.

8.2. Quality assurance

Delegates play a crucial quality assurance role within the aged care needs assessment system. It is the delegate's responsibility to ensure that due process is followed. Delegates are responsible for ensuring that the person being assessed genuinely requires government-funded aged care services. Additionally, delegates must ensure that any missing information or gaps in the required evidence have been identified, followed up, and clarified with the assessor. This is essential to support accurate, well-informed delegate decisions and uphold the integrity of the assessment process.



It is essential that assessment delegates maintain accuracy and consistency in their practice. Assessment delegates can do this by:

- Regularly consulting this Manual
- Regularly consulting the IAT User Guide to ensure IAT inputs are consistent with the guidance and definitions, including when determining whether an older person can complete an activity without help, with some help, or is completely unable to do so. This supports equitable decision-making.
- Note, quality assurance reviews by the Department will be undertaken to ensure assessment responses reflect the intent and guidance outlined in the IAT User Guide, and that the available evidence supports the level of need or assistance selected.
- Adhering to the Aged Care Assessment Quality Framework to ensure continuous monitoring and enhancement of assessment practices in alignment with the Framework's goals.
- Seek guidance in situations that are complex or uncommon e.g. from a Team Leader, Manager, Workplace Trainer, or another assessment delegate who can provide appropriate support and clarification.
- Understanding and adhering to the legal requirements set out in the *Aged Care Act 2024)*.

- Completing mandatory refresher delegate training every two years through MAClearning.

8.2.1. Validating the assessment process and evidence

To ensure evidence-based reasoning, and a commitment to fairness and accountability, it is essential that throughout the delegate decision making process assessment delegates:

- Validate the assessment process
- Review the assessment evidence

> Note: It is important that assessment delegates check that an individual's eligibility for an aged care needs assessment is thoroughly documented and supported by evidence. The Corrections and Reconsiderations sections in Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints, provide information on what assessment delegates should do if you have concerns about their eligibility for an aged care needs assessment.

8.2.2. Validating the assessment process

Assessment delegates must ensure that the correct assessment processes have been followed by the assessor. Section 62 of the *Aged Care 2024* (the Act) *Undertaking aged care needs assessments*, sets out how an aged care needs assessment must be completed and the key components it must include.

In line with the Act, assessment delegates must confirm the assessment:

- Was completed by an approved aged care assessor.
- Was completed using the Integrated Assessment Tool
- Used the appropriate assessment tools.
- Has appropriately evidenced and aligned recommended funded aged care services with the older person's immediate care needs.
- Includes a discussion with the older person about:
    - What the assessment has identified in terms of funded aged care services.
    - How recommended aged care services may assist the older person to maintain their independence.
    - The older person's strengths and motivations in setting individualised goals.
    - The next steps in their application for funded aged care services.
    - Advising the older person how they will be informed of the outcome of their application, including the expected timeframe for receiving a notice of decision, and the support available to help them make appropriate linkages to services as required.
- Involves the registered support persons if this was required and requested by the individual.

Assessment delegates can find further detail and guidance regarding best practice for the above steps in Chapter 5: Assessment activities and Chapter 6: Aged care programs of this manual.

> Note: Supporting independence, autonomy, empowerment and freedom of choice.

During the assessment, the assessor must ensure the individual they are assessing is aware of their rights under Section 23 Statement of Rights of the *Aged Care Act 2024* and support them to understand and empower them to exercise these rights.

8.2.3. Review the assessment evidence

Assessment delegates must ensure that all assessment information and documentation submitted by the assessor is accurate, relevant, and of high quality.

Assessment delegates must carefully examine the documentation to confirm:

- It provides a thorough and clear record of the entire assessment process.
- It demonstrates the assessor's reasoning.
- The evidence presented adequately supports their recommendations for aged care services.

Section 63 of the *Aged Care Act 2024* requires assessors to provide the assessment delegate with an accurate report of the assessment as soon as practicable after the assessment has been completed.

During the assessment, assessors are required to ensure all inputs into the IAT are accurate prior to finalising the IAT and submitting the assessment with the support plan to the assessment delegate for approval.

Assessment delegates must ensure that the assessment has been conducted correctly and that due process has been followed as outlined in sections 5.6 to 5.9 of this Assessment Manual. The assessment delegate must confirm that the individual being assessed genuinely requires government-funded aged care services, including identifying any missing information, inconsistencies, or gaps in evidence, and ensuring these matters are clarified with the assessor prior to making an access approval decision/s. This oversight supports accurate, well-informed, evidence-based delegate decisions and upholds the integrity of the assessment process.

If the IAT or the support plan lack sufficient detail, contain errors, or include inconsistencies, assessment delegates may use the 'Return to Assessor' functionality to return them for amendment to the assessor via the Assessment Portal. When doing so, delegates must clearly outline the required amendments and ensure that appropriate quality assurance checks are completed.

System Functionality for returning the IAT and/or support plan to the assessor for amendment

Only an assessment delegate can return the IAT or support plan to an assessor for edits, using the '*Return to Assessor'* function in the Assessor Portal. The functionality to return the IAT is not available in the Assessor App. When an assessment is returned, any delegate decisions marked as '*agree'* or '*disagree'* in the support plan are removed and must be actioned again once the amended assessment is resubmitted.

Delegates may select one of the following 'Return to Assessor' options:

- IAT amendments and Support Plan amendments
- Support Plan amendments only

The IAT can only be returned to an assessor for amendment once per assessment. However, the support plan may continue to be edited multiple times if required.

8.2.4. Assessment Delegate returning the support plan to the assessor for amendments

An assessment delegate may return the support plan to the assessor if the client's concerns and goals, service recommendations and assessment summary need amending before delegate approval. Returned assessments will display under 'Returned to assessor' in the Assessment Tab. 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. Assessors must ensure all service recommendations are aligned with the IAT Outcome and 'Recommended Classification.'

Once the revised support plan and assessment is resubmitted for delegation, assessment delegates must conduct a final review to check that it meets the required quality standards before granting final approval. To support continuous improvement, it is expected assessment delegates provide assessors with constructive feedback that promotes best practice and helps them understand and meet documentation expectations.

8.2.5. Assessment Delegate returning the IAT to the assessor for amendments

Where the assessment delegate identifies errors in the IAT, they may return the IAT to the assessor to apply requested changes. This function can be used once per assessment. Using this function is appropriate where factual errors are identified by the assessment delegate, including:

- inconsistencies between responses across the different IAT domains,
- incorrect entry of information in comparison to a clients' assessment summary, support plan, or relevant reports and supplied evidence,
- missing or incomplete information relating to the client's circumstances, and
- insufficient detail within IAT responses, including free-text fields.

Given the experience, clinical qualifications and extensive training undertaken by assessors and delegates, it is expected that question-level amendments will be limited and only requested where necessary to address identified errors, omissions or inconsistencies.

It is also expected that the need for these amendments will reduce over time, particularly as new assessors and delegates become more familiar with the IAT requirements.

To maintain appropriate role separation and independent review, the same person must not act as both the assessor and assessment delegate for the IAT amendment process.

When returning the IAT to the assessor, the delegate must complete a notes field with a template that lists all IAT domains.

It is not acceptable to leave the notes field blank or to enter a dash, placeholder text, or any other minimal entry to circumvent the requirement to provide clear and sufficient detail. The notes must clearly identify the amendments required and provide enough information to support why each amendment is being requested. This template is used to provide clear and

specific instructions to the assessor. For each relevant IAT domain, the delegate must identify:

- the specific question(s) requiring correction
- the nature of the correction required (for example, updating a response, providing further detail, or adding missing information) any additional Validated Assessment Tools (VATs) that must be completed. Where a VAT is completed as part of the IAT amendment process, there should be evidence available to demonstrate that contact has been made with the older person or their nominated supporter to obtain the required information. Most VATs can be completed via telehealth or may also be completed face to face if able. The DEMMI modified and all Cognition VATs should not be completed via telehealth. The DEMMI modified must not be completed over the phone, as it requires observation of the person's mobility and functional performance.



Assessor amending the IAT

Once the assessor receives the instructions from the delegate, they are required to action the requested changes in the relevant sections of the IAT. Refer to Appendix I of this Assessment Manual for further guidance on completing the notes template.

> Note: Clinical attendance remains vital and is still required as part of the assessment process. Non-clinical assessors must document all clinical supervisor(s) involved throughout the assessment process in the 'Notes to Delegate' section upon completion of the IAT amendments. Refer to section 5.7.1 of this Assessment Manual for further guidance on clinical attendance.

The assessor must also confirm all information is correct under each IAT domain, confirm that all goals were completed prior to completion of the IAT and then, select 'Finalise IAT,'

> Note: The system does not automatically return the updated IAT to the original delegate. Assessment organisations must have an internal process for assessors to notify the appropriate delegate when the IAT is ready for review. This process should also account for situations where the original delegate is unavailable (e.g. on leave) or where the required delegate type has changed following a new IAT Outcome (for example, from CHSP to SAH).

On finalisation of the IAT post-amendment, the system will generate a classification level for ongoing home support (referred to the IAT Outcome in the assessment workflow) which may be a Support at Home classification or CHSP level, or ineligibility for CHSP/SaH.

The new IAT Outcome may be higher or lower than the previous classification outcome, and if the intention is to recommend an ongoing Home Support Classification, the assessor must ensure the 'Recommended Classification' matches the new 'IAT Outcome' via the edit functionality (see 'Note' below for exception). If the assessor recommended a short-term pathway or 'ineligible for CHSP/SaH' for the purpose of recommending TCP and/or Residential care, this will remain displayed as the 'Recommended Classification.'

> Note: For existing clients already receiving Home Support, either with a Transitioned Home Care Package classification, or a Support at Home or CHSP classification, the new IAT Outcome may be lower than what they are currently

receiving. Assessors must ensure that the 'Recommended Classification' is equivalent to their existing classification. Please refer to Table 2 in Chapter 1 of this Assessment Manual. Assessors may have to make manual edits to the 'Recommended Classification' if necessary.

As per existing functionality, the assessor can override the 'Recommended Classification' to recommend a short-term pathway or Residential Care if required. If the new IAT Outcome recommends a different pathway (e.g. CHSP to SaH ongoing), the 'Convert to Comprehensive Assessment' functionality will continue as per current functionality.

The assessor must ensure all service recommendations in the Support Plan align with the updated care pathways recommended once the IAT has been amended.

The assessor is required to document all amendments completed in the IAT in response to the delegate's instructions in a notes field template. It is not acceptable to leave the notes field blank or to enter a dash, placeholder text, or any other minimal entry to circumvent the requirement to provide clear and sufficient detail. Non-clinical assessors are required to include all clinical supervisor(s) that were involved throughout the completion of the IAT. Assessment delegates must ensure that assessors have implemented all amendments to the IAT in accordance with the provided instructions, and that all required actions, including completion of an accurate Support Plan, have been completed as outlined above.

The assessor should not amend additional assessment responses beyond those identified by the delegate, unless further errors, omissions or inconsistencies are identified during the amendment process. Where this occurs, the assessor must clearly document the additional amendments and the reason they were required.



Delegate approval of the updated IAT

Once the assessment has been updated and re-submitted for approval, the Assessment Delegate will need to assign it to themselves after reviewing the 'Decision pending' list in the Assessor portal. This is because the system will not automatically return the updated IAT to the Assessment Delegate who requested the amendment. This process also applies to assessors who are Non-Clinical Delegates. Once assigned, the Assessment Delegate can action the assessment through the usual process

Assessment Delegates must ensure that assessors have implemented all amendments to the IAT in accordance with the provided instructions, and that all required actions, including completion of an accurate Support Plan, have been completed as outlined above.

When reviewing the client's Support Plan, the delegate will be able to view both the old and the new IAT Outcome which will display under the IAT Outcome and classification section. They will also be able to view the notes recorded by the assessor when the assessment was submitted for delegation. Once the algorithm has produced the new IAT Outcome, the new or amended outcome must be used for the assessment or support plan. The previous outcome cannot be selected or used.

Assessment delegates must ensure that amended IAT outcomes are implemented as determined by the IAT algorithm. Delegates are not authorised under the Act and Rules to override Support at Home classifications to a higher or lower level than the classification determined by the IAT, including where the IAT outcome has been amended.

Where a pattern of unlawful overrides are identified, the Department may take further compliance and assurance action. This may include requesting information from the Assessment Organisation, requiring corrective action to prevent recurrence, undertaking

targeted monitoring or assurance activity, and escalating the matter in accordance with relevant contractual, policy or legislative arrangements.

Once the delegate has recorded their decision and actioned as required, the assessment will flow back through to the assessor for finalisation as per existing process.

All information in both notes fields from the assessor and delegate will not be available after the assessment is finalised.

For further guidance on this process, refer to the *Assessor Portal User Guide 7, 10* and Appendix I of this Assessment Manual.

8.2.6. Assessment information and evidence

Assessment information and evidence should include all relevant documentation that supports the recommendations and decisions made throughout the assessment process. The assessment documentation must include:

- Consent
- Integrated Assessment Tool and Validated Assessment Tools
- Emergency Residential Care - Application for Care Form (where applicable)
- Additional Evidence
- Support plan and Recommendations
- Referral Information

Assessment Delegates must ensure that the assessment information contains comprehensive information to support the justification of the assessor's recommendation for funded aged care approvals. The following sections provide further detail on the requirements and how to ensure the evidence is sufficient.

Support plans

Under the *Aged Care Act 2024* (the Act), two key types of reports are required when assessing an individual's eligibility and needs for aged care services: the Assessment Report (as per Section 63) and the Classification Report (as per Section 77).

In practice, these reports comprise the support plan and the finalised Integrated Assessment Tool (IAT) respectively.

The support plan and its associated areas of concern, goals, and recommendations are among the most important pieces of needs assessment documentation available to the Assessment Delegate. The support plan helps determine whether to approve an individual for access to aged care services and must contain all relevant information from the older person's aged care needs assessment.

It is essential that the assessment summary is written clearly and succinctly, following the ISBAR format–Introduction, Situation, Background, Assessment, and Recommendation in Chapter 5: Assessment activities.

Particular emphasis should be placed on the Assessment section, as it typically forms the most substantial part of the summary. This section should comprehensively detail the findings of the assessment, providing a clear and accurate reflection of the individual's needs and circumstances.

The support plan must be consistent with the information collected using the IAT and any other relevant information gathered during the assessment, such as GP health summaries. The assessment summary should clearly inform the goals, recommendations, and any areas of concern outlined in the support plan. These elements should reflect what the person is concerned about, what they hope to achieve or change, and how funded aged care services can support them in addressing their needs and aspirations. Any cultural considerations or preferences expressed by the older person during the assessment or identified through the information gathering process should also be captured within the support plan to ensure culturally appropriate services are delivered. E.g. Whether older Aboriginal and Torres Strait Islander people would like to receive services from First Nations providers.

It is crucial that support plan recommendations are not just presented as a list of needs without context or explanation. Instead, the document should include clear elaborations on how each identified need was assessed and how this assessment informs the recommended care interventions or services.

When reviewing a support plan, assessment delegates should consider the following questions to ensure the documentation is thorough and meaningful:

- **Why is the person having a needs assessment?** - The support plan should clearly articulate the purpose of the assessment. Look for background information that explains the circumstances leading to the referral and the rationale for undertaking the assessment.
- **What are the older person's identified needs?** - Confirm that the support plan provides a comprehensive and evidence-based description of the older person's needs. This should encompass physical, medical, psychological and social domains as identified through the IAT and other validated assessment tools.
- **What types of support are required, and why?** - Ensure the support plan outlines the specific supports recommended along with a clear justification for each. These should be directly linked to the older person's assessed needs and supported by relevant evidence.
- **What barriers are limiting the older person's independence?** – Assess whether the support plan identifies any factors, such as cognitive impairment, physical limitations, or safety risks; that prevent the older person from performing tasks independently. These barriers must be clearly connected to the recommended supports and services.
- **What are the older person's concerns and priorities?** - Ensure the support plan accurately reflects the older person's concerns, perspectives and priorities. These may relate to safety, daily living, mobility, or social participation and should be acknowledged and addressed appropriately.
- **What goals does the older person wish to achieve with support?** – Verify that the support plan includes the older person's goals and desired outcomes. Ensure recommended supports align with these goals and demonstrate respect for the older person's autonomy, preferences and aspirations.
- **Are the recommended supports appropriate and proportionate?** - Evaluate whether the recommended services are reasonable, tailored to the older person's current circumstances and likely to achieve the intended outcome.

Once finalised, the support plan is sent to the older person, and their registered supporter/s and/or appointed decision makers as applicable, as a record of the assessment, accompanied by a Notice of Decision letter. Registered providers also use the support plan to inform the individual's care plan, therefore accuracy and clarity essential.

Referral information

The support plan will contain referral codes for services that have been approved and listed in the Notice of Decision letter, except where the referral code has not yet been issued.[6] or used to action a referral. Referral information is a vital component of the older person's record and typically consists of documents and notes gathered from various sources during the initial screening, triage, and assessment process.

In most cases, referral information will be attached to the older person's record or documented as 'client notes' within the My Aged Care assessor portal.

It is essential to use referral information when making a decision, as it provides important context and justification for any recommendations made.

Record of consent

Assessment Delegates must ensure that consent has been properly recorded in the system before making any approval decisions.

Consent is a mandatory part of the assessment process and must reflect that the older person—or their appointed decision-maker recognised under the Act—has agreed to the assessment and referral to services. This protects older person's rights and ensures decisions are made in accordance with legislative and procedural requirements.

Application for Care form

Older people seeking access to funded aged care services will not be required to complete an Application for Care Form. The act of applying for access to services will commence through one of the existing registration pathways (i.e. the My Aged Care contact centre or Aged Care Specialist Officers).

However, older people seeking access to residential care and emergency respite care will be required to complete an *Emergency Residential Care - Application for Care Form*. This form is used by providers and must be completed and submitted to the relevant assessment organisation, to confirm when they commenced receiving services.

Triage Delegates must review the form for completeness and be satisfied that the requirements under s58 are met. The Assessment Delegate is responsible for reviewing and approving the application form.

See the section titled *Further guidance Application process for people who have received aged care services but not yet applied for an assessment under My Aged Care* at the end of this chapter for more information.

Integrated Assessment Tool (IAT) and Validated Assessment Tools (VaTs)

The IAT and its VATs is the prescribed tool that assessors must use under s62-5 of the Rules. The IAT is essential for capturing a comprehensive profile of an older person's needs,

[6] At the time of delegate approval, the referral code will not yet be available when the older person is awaiting funding through the Support at Home, AT or HM Priority Systems.

ensuring accuracy and consistency in decision-making. The IAT consolidates key information about an older person's needs across a number of domains, providing a holistic view of their health and circumstances. Additionally, embedded validated tools assess abilities and capacity, forming a solid evidence base for determining care needs.

Assessment delegates must evaluate the information captured in these tools to determine an older person's eligibility for aged care services. This means cross-referencing the assessor's recommendations with the data recorded in the IAT to ensure the decision aligns with the support plan and matches the level and type of care identified during the assessment process.

If assessors choose to use any additional VATs beyond the IAT, assessment delegates must ensure they are uploaded as attachments to the 'client record.' This is essential for maintaining complete documentation.

Additional evidence

Assessment evidence can come from a range of sources, including letters or emails from health professionals such as geriatricians, GPs, or social workers. Additional useful documents might include written information from family or friends, GP medical summaries, completed AT-HM tier guide, hospital discharge summaries, and correspondence from current service providers, Care Finders, Elder Care Support workers, government or non-government agencies, or others involved in the older person's care. These documents offer valuable insights into the older person's needs and may help identify the type and urgency of required care and support.

Assessment organisations may also hold regular delegation meetings to review assessed individuals and ensure a multidisciplinary approach has been applied. These meetings help guide assessors in making well-informed recommendations before support plan submission and support assessment delegates, in fully understanding an individual's aged care needs, enabling accurate and informed decision-making.

> Note:
>
> If Assessment Delegates have any concerns about the quality or completeness of the evidence provided, it is important they discuss these with the assessor before proceeding with approvals. Assessment Delegates may also involve a manager or team leader in this discussion, if necessary, to ensure that all aspects of the assessment are properly addressed.

8.3. Approving home support

8.3.1. Step 1. Decide if the older person is eligible for home support

Before approving a recommendation for the home support service group, the Assessment Delegate first needs to decide if an older person requires and is eligible to access this service group. Please refer to section 7.6.1 Deciding if the older person requires aged care services and section 7.6.3 Section 67 – a person who has an impairment or sickness.

During the assessment, once the IAT is finalised, the IAT Outcome will generate a recommendation for the older person to receive ongoing home support through the Commonwealth Home Support Program (CHSP) or Support at Home (SaH). It may also

recommend ‘ineligible for CHSP/SaH.’ As such, the IAT Outcome will guide the Assessment Delegate to determine whether the older person is eligible for ongoing home support through CHSP or Support at Home.

> Note: An IAT Outcome of ‘ineligible for CHSP/SaH’ means that the older person has not met the minimum threshold to receive ongoing home support through CHSP or Support at Home.

8.3.2. Step 2. Decide the classification type and level

The IAT Outcome includes a service group (care type), classification type (duration) and classification level (funding). For example, a person who has been assessed as needing access to ongoing home support services under Support at Home, the approval will be the following:

- **Service group:** Home support
- **Classification type:** Ongoing
- **Classification level:** SAH class (1 to 8)

Section 81-10 of the *Aged Care Rules 2025* provides criteria that an older person must meet to be approved access for ongoing home support through CHSP or Support at Home. These criteria are based on a defined set of rules that has been built into the IAT to generate the IAT Outcome. This means that the IAT Outcome will determine whether the older person meets the criteria in section 81-10 of the Rules and the classification level (funding) for ongoing home support.

Chapter 5 provides guidance to assessors to accept the IAT Outcome if they are intending to recommend ongoing home support services through CHSP or Support at Home. Before approving any recommended classification level, assessment delegates must ensure that the classification level recommended by the assessor is the same as the classification level generated by the IAT Outcome. The system-generated recommendation is labelled ‘IAT Outcome,’ and the assessor’s recommendation is labelled ‘Recommended classification.’ If these two values are different, then the assessor has overridden the IAT Outcome.

In instances where the assessor has overridden the IAT Outcome to another ongoing home support classification (e.g. SaH class 4 to SaH class 5, CHSP to SaH class 1, ‘ineligible for CHSP/SaH’ to CHSP), the delegate must disagree with the assessor’s recommended classification level and edit it to the classification level recommended by the IAT Outcome.

> Note:
>
> It is necessary for the assessor to override a CHSP/SaH classification (or accept in the case of an ‘ineligible for CHSP/SaH) generated by the IAT Outcome to recommend the following pathways:
>
> ○ SaH Restorative Care Pathway,
>
> ○ SaH End-of-Life Pathway.
>
> ○ Transition Care Program without ongoing in-home services,
>
> ○ Permanent Residential Care without ongoing in-home services,

- Residential Respite care without ongoing in-home services.

Assessors may also approve an ongoing home support classification (SaH) alongside TCP and Residential Care and select 'not seeking services' to avoid a reassessment being required for the older person.

Approving CHSP services alongside Support at Home classifications

Under the *Aged Care Act 2024* (the Act), an older person cannot be approved for the Commonwealth Home Support Program (CHSP) class at the same time as any Support at Home (SaH) classification level (SaH class 1-8, SaH Restorative Care Pathway or SaH End-of-Life Pathway).

In limited circumstances, SaH participants can access additional CHSP services if approved and assessors can issue referrals for CHSP services for individuals with a SaH classification.

See tables 29 and 30 in Chapter 6 for further details about when an individual with a Support at Home classification can be approved to access CHSP services.

Approving the SaH Restorative Care Pathway

Each financial year, 20,000 Restorative Care units of funding will be available nationally, distributed across four quarters at approximately 5,000 units per quarter. These units of funding are limited and must be carefully allocated to ensure the pathway remains sustainable and appropriately targeted to individuals with short-term restorative care needs. Assessors will be able to recommend Restorative Care Pathway (RCP) regardless of the caps on units of funding. The Assessment Delegate may not approve this recommendation if RCP units of funding have run out.

For SaH participants receiving ongoing services at the time the RCP is approved, the RCP episode can be accessed concurrently with their ongoing services. This allows individuals to continue using their ongoing services while also receiving additional, clinically focused services through RCP.

However, it is important to ensure that services provided under RCP are complementary to ongoing services. The restorative care partner and ongoing care partner should ensure coordination of services to achieve this.

Services delivered through RCP should focus on reablement and allied health and/or nursing interventions—aimed at improving function and independence, rather than duplicating routine or maintenance care.

For those already accessing ongoing care, assessors should carefully consider ongoing needs before recommending RCP. Assessors cannot recommend a new higher classification and the RCP at assessment. This will impact a new ongoing classification entry into the SaH Priority System.

For new individuals being assessed for SaH and considered for RCP, eligibility for ongoing services will need to be determined at the end of the RCP episode. Individuals cannot be simultaneously approved for both RCP and an ongoing SaH or CHSP classifications at the time of assessment.

When selecting the RCP, an assessor will not be able to select a new ongoing classification.

For those accessing ongoing services, an assessor may select a new ongoing SaH classification **or** RCP. If RCP is selected, the person will automatically retain their current classification.

Note:

The IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs. Where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.) An ongoing SaH classification must be generated by the IAT to override and recommend RCP for approval.

To recommend the RCP classification, the individual must have received an initial ongoing SaH classification through the IAT Outcome. This is then overridden by the assessor to recommend the RCP.

Participants assigned to the RCP who have an assessed need for AT and / or HM will be allocated AT-HM funding immediately.

After a restorative care episode, a participant will undertake a reassessment to get approval for an ongoing classification and be placed in the SaH prioritisation system, if required.

Approving restorative care - guidance for assessment delegates

An assessment delegate is responsible for approving access to the RCP. The assessment delegate can only approve someone for RCP if all eligibility criteria are met. They may consider if places are available for allocation. The assessment must clearly show that the individual is likely to benefit from short-term, multidisciplinary allied health and/or nursing support aimed at improving their function and independence. An assessment delegate must make sure that their decision is backed by appropriate evidence.

> Note: To be approved for the RCP, the older person must not be in hospital or residing in permanent residential care at the time of the assessment. The older person must be residing in the home or community setting.

The assessment delegate is also responsible for making sure all decisions follow pathway rules, including:

- The person has not already been approved for two units of funding for Restorative Care in the past 12 months.
- It has been 90 days from the maximum period of effect from a previous episode of Restorative Care.
- For the relevant transition period, delegates should also confirm if a person has accessed RCP through a Short-term Restorative Care (STRC) approval to determine eligibility for further RCP funding units.

If an additional unit of funding is requested through a support plan review (SPR), the assessment delegate must ensure that the documentation clearly explains the reason, how it links to the person's goals, and that evidence is provided to support your decision. The assessment delegate's role in reviewing and approving these cases is essential to making sure the RCP is used fairly, consistently, and in line with the pathway's goals of early intervention and reablement. Availability of RCP units may also be considered.

If the participant is accessing two separate episodes of restorative care, they will need to wait at least 3 months from the end of the 16 weeks period associated with the original episode before being eligible to receive a second episode within the 12-month period.

An RCP recommendation may not be approved if there are no RCP places available for allocation. The assessor may contact the older person to discuss alternative supports for recommendation.

> Note: Decisions made about RCP through the IAT are made under s65 and s78 which are reviewable decisions under the Act. Decisions made about the additional unit of Restorative Care Pathway funding through an SPR are made under section 195-3 of the Rules and are not reviewable.

Eligibility considerations and exclusions

An individual **cannot** access the Restorative Care Pathway (RCP) if they:

- Are receiving, or are eligible to receive, the End-of-Life Pathway
- Have been approved for two episodes or two separate units of Restorative Care funding within the past 12 months or have recently accessed Restorative Care (a 90

day gap is required from the end of the 16-week period associated with the first episode of care).

- Are receiving, or are eligible to receive, services under the Transition Care Program
- Are in permanent residential aged care.

Individuals who have been approved for the RCP may access services through Multi-Purpose Services Program or National Aboriginal and Torres Strait Islander Flexible Aged Care Program, if eligible for those programs and in-line with program rules.

Assessment delegates should be aware when a client who has an ongoing SaH classification and is reassessed for the RCP there is no impact on the person's current ongoing SaH classification or position in the SaH Priority System. A new ongoing SaH classification and RCP are unable to be recommended at the same time. Assessors and Assessment Delegates should consider a person's current ongoing needs before recommending the RCP episode. If an older person needs a new ongoing classification, they will need to be reassessed following the RCP episode.

Manual oversight of restorative care places

RCP places are capped at 20,000 units per year, managed as around 5,000 units per quarter. From 1 November 2025, system-based visibility of Restorative Care units will not be available. As a result, there will be no in-system prompts or controls to prevent the approval of RCP funding units beyond the quarterly caps. Weekly reports of approvals made will be generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

In addition to RCP approvals confirmed after 1 November 2025, those with an active Short-Term Restorative Care (STRC) approval (who did not start STRC before 1 November 2025), will have their approvals transferred into an approval for RCP.

Note for this cohort using their STRC approval to access the RCP: they will also be accessing the RCP units of funding for the first six months from 1 November 2025.

A second unit of funding to use within a single RCP episode can be requested via a support plan review (SPR) request noting the assessor will need to self-refer this for reassessment to grant access to a second unit of funding (see Chapter 6).

The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request. Availability of the RCP funding units may also be considered. When a request for a second unit of RCP is received assessors should confirm if there is approval for STRC and RCP on the client's record. If there is approval for both, the assessor will need to confirm with the client if they entered care under the RCP after 1 November 2025 using the STRC approval. If this is the case, then the assessor must not approve a third unit of RCP funding.

If the participant is eligible to access an additional restorative care pathway they must wait at least 12 months before accessing another episode.

Assessment delegates will need to remain acutely aware of any communication from the department regarding RCP caps to ensure they are making informed decisions. These communications will be the **primary tool** for identifying when the allocation of RCP units are close to being fully utilised. Being responsive to these insights is essential for maintaining compliance with pathway limits and avoiding over-allocation.

Restorative care funding

The Restorative Care Pathway (RCP) provides around $6,000 of funding (one unit), for up to 16 weeks. The total amount of funding a participant uses and length of time to complete an episode can differ. Restorative care partners will consider this when developing the goal plan.

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode. If the participant requires additional funding within a single 16-week episode, the provider can submit a request for a support plan review. If certain circumstances are met, approval can be given for the additional $6,000 in funds to support the episode.

If approved, a participant can access an additional unit of funding (up to $6,000), to provide a combined total of up to $12,000 (two units), for a single episode of restorative care. If additional funding is approved, a participant will not be eligible for a further episode of restorative care within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

Important:

- The decision to approve additional concurrent funding to the RCP episode is made under subsection 195-3 of the *Aged Care Rules 2025 (the Rules)*. It is a non-reviewable decision. The criteria in the Rules includes that required evidence must be given by the participant's provider and there must be units of funding available for approval.
- The assessment delegate must send a letter to the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) notifying them of the outcome of the application for the additional funding.

Approving the End-of-Life Pathway

The End-of-Life (EoL) Pathway is one of the short-term home support classifications under the Support at Home program. It provides 12 weeks of funded support at around $25,000 for older people who are medically assessed to have three months or less to live and have an Australian-modified Karnofsky Performance Status score of 40 or less. The pathway is designed to enable people to remain at home with appropriate care during their final stage of life.

End-of-Life Pathway form

The End-of-Life Pathway form is used to document the required medical evidence for accessing the End-of-Life Pathway under the Support at Home program. An individual seeking access to the End-of-Life Pathway must complete all relevant sections and present this form to a medical practitioner or nurse practitioner for completion. The completed form should then be submitted as part of the assessment process—either before or during triage, or assessment—and reviewed to confirm eligibility for the End-of-Life Pathway.

The assessment delegate is responsible for verifying the completion of this form in the older person's record when the End-of-Life Pathway has been flagged in the My Aged Care assessor portal.

Reviewing the form will involve:

- Checking the individual's details to ensure they match the record in the portal.

- Verifying the completion of all areas of the Medical Assessment section to confirm
    - The individual has a prognosis of a life expectancy of three months or less, and
    - An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
    - Medical practitioner or nurse practitioner has completed and signed the form.

An individual will **not** be eligible for approval for the End-of-Life Pathway if the required criteria outlined in the medical assessment section are not met.

8.3.3. Step 3. Decide the service types and services

Older person is Aboriginal and Torres Strait Islander

If the older person is an Aboriginal or Torres Strait Islander person, the *Aged Care Act 2024* (the Act) provides that they only need to be approved for one or more service groups. That is, under the Act they are automatically approved for all the service types and services in any service group they are approved for. However, an Assessment Delegate will still need to make sure that all the service types and services they are approved for are selected in the system (more guidance on this follows below).

Older person is neither Aboriginal nor Torres Strait Islander

If the older person is not an Aboriginal or Torres Strait Islander person, and an Assessment Delegate is approving the Home Support, Assistive Technology or Home Modifications service groups, they must decide:

- which service types to approve them for within each service group
- which services to approve them for, but only if the Assessment Delegate is approving the following 'prescribed' service types: *Allied health and Therapy* and *Therapeutic Services for Independent Living.*

For any service type other than *Allied health and Therapy* and *Therapeutic Services for Independent Living* (the 'non-prescribed' service types), if an Assessment Delegate thinks the older person needs any service in the service type, **then they need to make sure that all services in the service type are selected.**

Check to make sure all required services are selected (particularly for CHSP)

The system currently allows services to be de-selected in the non-prescribed service types, which leaves open the possibility that services the person is actually entitled to are left out.

Assessors and Assessment delegates need to carefully check to **make sure that all the required services have been selected**. This is particularly important for any approvals given under CHSP, as the services under the service type are not pre-selected in the system. This avoids having to undertake an SPR to add the necessary services.

Recording the decision for Support at Home classes (ongoing and short-term)

This process applies if the approved classification level (labelled 'classification' in the system) is any of the following:

- SAH class 1 to 8
- SAH Restorative Care Pathway
- SAH End-of-Life Pathway.

> Note:
>
> The Support at Home AT-HM scheme is referred to as a 'short-term pathway.' Under the Act, the AT-HM scheme is enabled through the Assistive Technology and Home Modifications service groups. AT-HM can be added to an older person's support plan, if there is an assessed need, after adding one of the ongoing or short-term Support at Home classifications above.

Review CHSP service recommendations

Assessment delegates should review any CHSP service recommendations listed. If they disagree with any of them, they should contact the assessor to discuss and amend the list if required.

Assessment delegates are able to record their agreement or disagreement alongside each CHSP service recommendation in the assessor portal. An assessment delegate's decision to agree with the recommended CHSP services will be automatically recorded in the Notice of Decision.

8.3.4. Step 4. Confirm the priority category

Access to the ongoing Support at Home classifications (SAH classification 1 to 8) will be prioritised using information collected during the assessment process and on the client's record, through the Support at Home Priority System.

An older person's priority category is determined by the prioritisation algorithm based on a standardised set of seven criteria. The seven criteria have 'points' allocated to them, and how many points an individual has determines their eligibility for a priority category of Urgent, High, Medium, or Standard.

The AT-HM scheme has its own priority systems, and these are described further under the section *Approving AT and HM under Support at Home*, below.

The seven criteria captured in the IAT or on the client's record that calculate the Support at Home priority category are whether the person:

1. lives alone (1 point)
2. identifies as Aboriginal or Torres Strait Islander (1 point)
3. has an assessed cognitive impairment (1 point)
4. is experiencing homelessness or is at risk of homelessness (1 point)
5. requires urgent ongoing service provision (2 point)
6. waited more than six months between assessment referral and completion and lives in a rural or remote area (in a Modified Monash Model category 5, 6, or 7 area) (1 point)

7. has Motor Neurone Disease (MND) (5 points)

Assessment Delegates should check the responses to the seven fields above to make sure that the correct inputs are recorded.

> Note:
>
> Assessment delegates will not know the priority category until after they click the 'Save and Delegate' button in the portal.

The four priority categories are as follows:

Table 47. Priority categories for ongoing Support at Home classifications

Urgent	The older person has five or more points.
High	The older person has four points.
Medium	The older person has two or three points.
Standard	The older person has one or no points.

The priority category will be displayed under 'Approvals for a Client' in the Assessor Portal.

The system will automatically recalculate an older person's priority category (if required) when changes are made to the following fields in their client profile:

- Accommodation type
- No fixed address
- Lives With
- Aboriginal and Torres Strait Islander Status

8.3.5. Step 5. Confirm service seeking status (ongoing Support at Home classifications only)

As part of the assessment process, assessors are expected to have a clear conversation with the individual about whether they are seeking to receive services through the Support at Home program. This helps ensure the individual's current needs are met and supports fair and timely access to services for others. When individuals who are not actively seeking services through the Support at Home program remain on the Support at Home Priority System, it can cause delays for those who are ready and actively seeking services.

Before referring the client for services, the assessor should confirm with the client if they wish to seek home support from the Support at Home program and record their preference in the support plan:

- For clients seeking to access their ongoing home support through the Support at Home program, the assessor should set the service seeking preference for the ongoing SaH classification to 'seeking services'
- For clients not seeking to access their ongoing home support services through the Support at Home program, the assessor should set the service seeking preference for their ongoing SaH classification 'not seeking services.' The assessor should do this for clients who choose to access services through NATSIFACP or MPSP and so do not require services from a Support at Home provider. This option makes sure the client does not enter the Support at Home Priority System and so is not allocated funding under Support at Home.

If the older person later wants to use their ongoing SaH classification through the Support at Home program, they can change their preference and enter the Support at Home Priority System. Their wait time will be counted from their original access approval date of effect. That is, it will be as if they had stayed in the queue from their first approval. They can change their preference by:

- contacting My Aged Care
- using the My Aged Care Online Account.

Assessment Delegates are responsible for confirming that the client's preference–whether to seek or not seek services through the Support at Home program–has been accurately recorded in the support plan and that it aligns with their assessed needs.

8.4. Approving Assistive Technology and Home Modifications under Support at Home

This section relates to approving Assistive Technology (AT) or Home Modifications (HM) under the AT-HM scheme. The AT-HM scheme is one of the short-term pathways of the Support at Home (SaH) program. To be approved for the AT-HM scheme, the older person must also be approved for home support with a SAH classification level. A later section will show how to approve AT or HM when the classification level of the older person is *CHSP class*.

8.4.1. Step 1. Decide if the older person is eligible for AT or HM

Before approving a recommendation for AT and/or HM, an Assessment Delegate first needs to decide if an older person requires and is eligible to access one or both of these service groups.

Existing questions in the IAT will help to identify and determine an older person's need for AT or HM. For example, the purpose of the function section is to understand a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

As part of an Assessment Delegate's decision-making, they must consider whether the older person:

- has needs and goals that could be met through using assistive technology or home modifications, or both
- can have those needs met through the assistive technology or home modifications service groups, and therefore the products, equipment and home modifications on the AT-HM list.

8.4.2. Step 2. Approve the classification type and level (funding tier)

Assessment Delegates are responsible for approving the classification type (ongoing or short-term) and funding tier for AT and HM recommended by the assessor. Once approved, funding must be used within the 12-month period (in most instances).

A 'funding tier' for AT-HM has been implemented as a 'classification level' under the *Aged Care Act 2024* (the Act). These funding tiers determine the maximum budget (except for AT high tier where there is no maximum budget) available and are valid for 12 months (in most instances) from the date the individual started care with their provider (as notified by the provider in the start notification for the person).

Individuals can access AT ongoing (assistance dogs) and short-term and HM tiers concurrently if needed and may be required to contribute financially depending on the category of support.

The cost of prescription and wrap-around services—such as delivery, setup, training, and follow-up—are also drawn from the AT-HM funding tier. Providers may charge:

- up to 10% of the cost of the item or item bundle or up to $500 (whichever is lower) on administration costs for AT.
- up to 15% of the total quoted cost of a participant's home modification or up to $1,500 (whichever is lower) on coordination costs for HM.

The AT-HM funding tier must align with the individual's assessed needs and be documented in their support plan. An Assessment Delegate's approval ensures appropriate funding allocation, program compliance, and timely access to essential supports.

Assessment Delegates must consider the costs of prescription and wrapround services when approving a funding tier.

An individual is not eligible for the AT-HM scheme if they are currently receiving permanent residential aged care.

AT-HM scheme funding tiers

If AT or HM are approved, individuals will be assigned a funding tier for AT, HM, or both - based on their assessed needs.

Table 48. Funding tiers for both AT and HM: Low, Medium and High

Indexation will be applied to the below amounts; indexation will occur on 1 July and 1 August 2026. For the latest budget information, please go to: Schedules of Subsidies and Supplements for Aged Care | Australian Government Department of Health, Disability and Ageing

Funding tier	Funding allocation cap	Funding period
Assistive technology		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000[1] (nominal)	12 months
[1] Participants can access more than $15,000 with a prescribed need.		
Home modifications		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000	12 months[2]
[2] Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence is provided to Services Australia		
Other funding		
Assistance dog maintenance	$2,000 per year	Ongoing[3]
[3] Funding for assistance dog maintenance will be automatically allocated every 12 months; however, the funding cannot accrue or rollover.		

An AT-HM tier guide has been developed to assist assessors to make a funding tier recommendation for assistive technology and/or home modifications based on the older person's assessed need in the IAT. This includes considering their current functional ability and home environment. The guidance has been designed to consolidate the main elements of the IAT relevant to AT-HM to support assessors in choosing a funding tier. The guide will suggest a funding tier which should sit where the majority of tier indicators have been selected. Assessors should ensure their recommendations align with the participant's goals, safety, independence, and overall ability to remain living at home. They may choose to select an alternate tier if funding does not align with assessed need. Assessors can upload the document as an attachment to allow Assessment Delegates to review as supporting evidence for any funding tier recommendations made.

The assessment delegate may also use the completed AT-HM tier guide, uploaded by the assessor, to review evidence related to the decision making process on allocation of a particular AT or HM funding tier.



See APPENDIX G – AT-HM terms for further information regarding the AT-HM Terms and Chapter 6: Aged care programs for AT-HM case studies

AT-HM list

The AT-HM list sets out the equipment, products and home modifications that are available for Support at Home participants under the AT-HM scheme. The AT-HM list sits under the main Aged Care Service list, which lists all other services and service types.

The list was constructed using the internationally agreed instruments and Australian-adopted AS/NZS ISO Assistive Product- classification and terminology standard (2023) and informed by subject matter experts.

Participants may use their AT-HM scheme funding on items listed under 'Inclusions' where an assessed need is documented in their support plan. Conditional inclusions are subject to additional criteria.

Home modification items are included on the AT-HM list. Services associated with the sourcing, supply and provision of the home modification products on the AT-HM list, such as installation, fitting, council approval and planning, will also be funded through the AT-HM scheme.

The AT-HM list includes the following categories:

- managing body functions – including pressure cushions, anti-oedema stockings and memory support products
- self-care products – including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- mobility products – including walking frames, wheelchairs and lifting devices
- domestic life products – including assistive products for food preparation, eating, drinking and house cleaning
- communication and information management products – aids that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices
- home modifications - including accessible showers, grabrails, fixed ramps and safety barriers.

The AT-HM list

The AT-HM scheme guidelines

8.4.3. Step 3. Confirm the priority category

The AT-HM scheme has separate priority systems to the Support at Home Priority System, as the funding is separate. The AT-HM scheme has an Assistive Technology Priority System and a Home Modifications Priority System that allocate AT and/or HM funding. An older person assessed as eligible for AT and/or HM will enter the AT-HM Priority Systems in one of its three priority categories (high, medium, standard). The older person will not be able to access AT-HM under Support at Home until funding has been allocated. The amount of time they wait for services will depend on the priority category they are in.

Older people receiving AT or HM funding under EoL,RCP or if they have Motor Neurone Disease (MND) will be a high priority and have their funding immediately allocated.

The AT-HM Priority Systems ensure the equitable allocation of funding based on standardised criteria determined using information collected by the aged care assessor through the IAT.

The criteria captured in the IAT or on the client's record that calculate the priority category are:

1. Individual lives alone
2. Individual has an assessed moderate or severe mobility impairment
3. Individual is an Aboriginal or Torres Strait Islander person
4. Individual's current place of residence poses a moderate to severe risk to their health or safety
5. Individual has waited more than six months between assessment referral and completion and lives in a rural or remote area (in a Modified Monash Model category 5, 6, or 7 area)

Individuals who have MND or are being approved for the Restorative Care or the End-of-Life pathways under Support at Home will have immediate access to any AT-HM funding allocated. Note that the system will display an AT-HM priority of 'High' in this scenario, but the funds are allocated immediately. Further information is available in the AT-HM scheme guidelines.

Although the system calculates priority automatically, the Assessment Delegate should check the responses to the five fields above and if a participant has MND to make sure that the correct priority category is applied.

Note the priority category will not be displayed until **after** you click the 'Save and Delegate' button in the portal. The Priority Category will be displayed under 'Approvals for a Client' in the My Aged Care Assessor Portal.

8.4.4. Step 4. Confirm service seeking status (AT-HM)

Assessment Delegates are responsible for confirming that the individual's preference—whether to seek or not seek AT-HM funding through the Support at Home program—has been accurately recorded in the support plan and that it aligns with their assessed needs.

Assessors are expected to confirm with the client if they wish to seek AT-HM funding from the Support at Home program and record their preference in the support plan.

- **For clients seeking AT and/or HM services through the Support at Home program**, the assessor should set the AT and/or HM service seeking preference to 'seeking services.' This ensures that the older person is placed on the AT and/or HM Priority System(s).

- **For clients <u>not</u> seeking AT and/or HM services through the Support at Home program**, the assessor should set the AT and/or HM service seeking preference to 'not seeking services.' This option makes sure the client **does not** enter the AT or HM Support at Home Priority Systems, and so is not allocated funding under the AT-HM scheme. Relevant circumstances include when:
    - the client has chosen to access services through NATSIFACP or MPSP and so they do not require services from a Support at Home provider (or funding from the Support at Home program)
    - the client does not want to access AT and/or HM services at this time.

There are separate AT and HM Support at Home Priority Systems with independent 'service seeking' statuses for each. This means that if the older person is approved for both AT and HM, they may seek services through the Support at Home program for one, both or neither.

If the older person later wants to access their AT or HM services through the Support at Home program, they can change their preference and enter the AT or HM Priority Systems. The older person will need to be a Support at Home participant (for ongoing home support) to do this. Their wait time will be counted from their original access approval date of effect. That is, it will be as if they had stayed in the queue from their first approval.

An older person can change their service seeking preference by:

- contacting My Aged Care
- using the My Aged Care Online Account

Note:
Participants assigned to the Restorative Care Pathway or the End-of-Life Pathway who have an assessed need for AT and HM will be allocated AT-HM funding immediately.

8.5. Approving AT and HM under CHSP

This section relates to approving AT or HM for an older person who are also approved for ongoing home support with a classification level of CHSP class.

8.5.1. Understanding AT and HM under CHSP

Under the *Aged Care Act 2024* (the Act), AT and HM services are available to older people under the CHSP. The relevant service types will be:

- **Home adjustments**: subsidised home modifications up to $15,000 per year.
- **Equipment and products:** subsidised low-cost equipment and products with funding up to $1,000 per year in total (not per item).

There are no funding tiers for AT or HM under CHSP.

Under the Act, eligible people will be approved for:

- the home support service group with a classification level CHSP class, and
- the assistive technology service group with a classification level of AT CHSP or
- the home modifications service group with a classification level of HM CHSP.

8.5.2. Step 1. Decide if the older person requires AT or HM under CHSP

Before approving a recommendation for AT or HM, Assessment Delegates first need to decide if an older person requires and is eligible to access one or both of these service groups.

Existing questions in the function section of the IAT will help to identify and determine an older person's need for assistive technology or home modifications. The purpose of the function section is to understand a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

When reviewing the assessment and IAT, Assessment Delegates will need to consider whether the older person's:

- needs and goals that could be met through using assistive technology or home modifications
- can have those needs met through the services under Assistive Technology and Home Modifications

8.5.3. Step 2. Review service recommendations for AT or HM under CHSP

Service recommendations represent referrals that can be made through the Assessor Portal to Commonwealth-subsidised aged care services.

Review the service recommendation details for CHSP Assistive Technology and CHSP Home Modifications including:

- service type and service (sub-type) – if applicable
- For Assistive Technology services, assess whether an allied health assessment is required. If it is required, include an appropriate service recommendation, such as Allied health – Occupational therapy or Physiotherapy referral, alongside the Assistive technology referral.
- Assessors may also need to recommend Assistive technology services where an Allied health service (if applicable) is required to assess the client's equipment needs.
- start, end and review date – if applicable
- frequency, intensity
- priority
- outcome

8.5.4. Changes to Specialised support services under CHSP

Specialised support services (SSS) are not included on the Aged Care Act 2024 service list. These services have been remapped to other service types on the legislated Aged Care Service List.

Some providers will continue to deliver specialised clinical **vision support services** under SSS to individuals living at home who need Orthoptic services and/or Vision orientation and mobility support. Braille training is covered under "Vision orientation and mobility services".

Note: Assessors should **not** refer for SSS unless the client requires the specialised clinical vision supports identified above.

Service referrals should be made using the appropriate remapped service category as outlined below:

Continence advisory services

If the client requires **clinical** support for **continence** related issues, they must be referred to a provider delivering “Nursing care”
If the client requires **non-clinical** support for **continence** related issues, they must be referred to a provider delivering “Personal care – Continence management (non-clinical)”

Hearing advisory services

If the client requires **non-clinical** support on an **individual** basis for a **hearing impairment** diagnosis, they must be referred to a provider delivering “Social support and community engagement – Individual social support”
If the client requires **non-clinical** support in a **group** setting for a **hearing impairment** diagnosis, they must be referred to a provider delivering “Social support and community engagement – Group social support”
If the client requires **non-clinical** support on an **individual** basis for a **hearing impairment** diagnosis to help with personal affairs, they must be referred to a provider delivering “Social support and community engagement – Assistance to maintain personal affairs”
If the client requires **clinical** support for a **hearing impairment** diagnosis, they must be referred to a provider delivering the appropriate clinician-led service under “Allied health and therapy” or “Nursing care”.

Dementia advisory services

If the client requires **clinical** support for a **dementia** diagnosis, they must be referred to a provider delivering the appropriate clinician-led service under “Allied health and therapy” or “Nursing care”.
If the client requires **non-clinical** support on an **individual** basis for a **dementia** diagnosis, they must be referred to a provider delivering “Social support and community engagement – Individual social support”
If the client requires **non-clinical** support in a **group** setting for a **dementia** diagnosis, they must be referred to a provider delivering “Social support and community engagement – Group social support”
If the client requires **non-clinical** support on an **individual** basis for a **dementia** diagnosis to help with personal affairs, they must be referred to a provider delivering “Social support and community engagement – Assistance to maintain personal affairs”

Client advocacy services

If the client requires support on an **individual** basis, they must be referred to a provider delivering "Social support and community engagement – Individual social support"
If the client requires support in a **group** setting, they must be referred to a provider delivering "Social support and community engagement – Group social support"
If the client requires **cultural support**, they must be referred to a provider delivering "Social support and community engagement – Cultural support"

Other clinical advisory support

If the client requires **non-clinical** support on an **individual** basis for a particular impairment or condition, they must be referred to a provider delivering "Social support and community engagement – Individual social support"
If the client requires **non-clinical** support on an **individual** basis to help with personal affairs, they must be referred to a provider delivering "Social support and community engagement – Assistance to maintain personal affairs"
If the client requires **non-clinical** support in a **group** setting for a particular impairment or condition, they must be referred to a provider delivering "Social support and community engagement – Group social support"
If the client requires **clinical** support for a particular impairment or condition, they must be referred to a provider delivering the appropriate clinician-led service under "Allied health and therapy" or "Nursing care".

Vision advisory services

If the client requires **clinical** support for a **vision impairment** diagnosis **AND requires either orthoptic services OR vision specific orientation and mobility services**, the client should receive a referral for "Specialised support services – Vision advisory services"
If the client requires **clinical** support for a **vision impairment** diagnosis, they must be referred to a provider delivering the appropriate clinician-led service under "Allied health and therapy" or "Nursing care".
If the client requires **non-clinical** support for a **vision impairment** diagnosis on an **individual** basis, they must be referred to a provider delivering "Social support and community engagement – Individual social support"
If the client requires **non-clinical** support on an **individual** basis for a **vision impairment** diagnosis to help with personal affairs, they must be referred to a provider delivering "Social support and community engagement – Assistance to maintain personal affairs"
If the client requires **non-clinical** education and training on how to use devices that assist them at home, they must be referred to a provider delivering "Social support and community engagement – Digital education and support"

These changes do **not** affect:

- access to support
- provider involvement

Clients can still access the services they require but under a different service referral (not SSS).

If assessment organisations have any questions or concerns contact: SSSConsultation@health.gov.au.

8.6. Approving permanent residential care

8.6.1. Step 1. Decide if the older person requires ongoing residential care

Permanent residential care is delivered through the service group residential care and an access approval for the ongoing classification type. It is provided by registered providers in approved residential care homes.

Before approving a recommendation for residential care, Assessment Delegates first need to decide if an older person requires and is eligible to access this service group.

There is one key point to remember when deciding on access for non-Aboriginal or Torres Strait Islander people. **Section 68** of the *Aged Care Act 2024* (the Act) requires these older people to have a continuing need for funded aged care services because of sickness in order to access the residential care service group. Assessment Delegates need to be satisfied, that the person's sickness at the time of assessment means that they have a continuing need for residential care.

8.6.2. Step 2. Confirm the priority category

To meet the requirements of the Act, an older person being approved for permanent residential care will be assigned a priority category (1, 2 or 3). The priority category is not currently being used to prioritise access to residential care.

Table 49. Priority categories for permanent residential care

Category #	Description
1	The person: • has a high urgency rating; or • resides in a rural or remote area classified as MM 5, MM 6 or MMM 7; or • is Aboriginal or Torres Strait Islander, homeless, or is entering residential care due to emergency circumstances.
2	The person does not meet the criteria for Priority Category 1 and has a medium urgency rating.
3	The person does not meet the criteria for Priority Category 1 and has a low urgency rating.

The priority category is automatically generated by the assessor portal based on the individual's circumstances, urgency rating and in accordance with the criteria specified by the *Aged Care Rules 2025* (the Rules).

Assessment Delegates need to verify that the urgency rating assigned to the individual accurately reflects their needs and are supported by the evidence provided.

8.6.3. Urgency rating for residential care

A person's urgency rating is different to their need for residential care.

When selecting Residential Permanent assessors will be required to give a response to ' What is the urgency of this care type.' This question is a mandatory question with a rating to be selected from high, medium or low.

The Rules specify when an urgency rating of low, medium or high will apply to an individual in relation the classification type ongoing for residential care. The table below summarises the criteria for each urgency rating.

Table 50. criteria for urgency ratings for residential care

Urgency rating	Description
High urgency	**This rating applies if:** • The individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk. **Indicators**: Recent falls, hospital admission, unsafe to return home, severe decline. **Example**: A client in hospital post-fall who lives alone and whose needs exceed Home Care supports.
Medium urgency	**This rating applies if:** • The circumstances for a high urgency rating do not apply to the individual; and • When considering the individual's circumstances and preferences, the individual is expected to seek access to permanent residential care within the next 6 months. **Indicators**: Declining function, rising carer stress, complex but not urgent risks. **Example**: A client with moderate incontinence and cognition issues whose carer is overwhelmed.
Low urgency	**This rating applies if**: • The circumstances for a high or medium urgency rating do not apply to the individual.

Urgency rating	Description
	Indicators: Some decline, minor falls, current supports are working, client prefers to delay move. **Example**: A client managing at home with informal support but thinking about future needs.

Note: The urgency rating reflects how soon an individual needs residential care to avoid significant risk to their health or safety. This is separate from whether they *require residential care* or have *high-level care needs*—it's about the *timing* of that need.

Assessors are expected to select the rating which balances objective consideration of needs with the subjective perspective of the older person and/or appointed decision maker/s. Assessors should include a brief note in the *reason or comments* section explaining key reasons for the rating. See Chapter 6 for more information.

8.7. Approving residential respite care

8.7.1. Step 1. Decide if the older person requires short-term residential care

Like permanent (ongoing) residential care, residential respite is delivered through the service group residential care. Access to residential respite requires an access approval for the short-term classification type. It is provided by registered providers in approved residential care homes.

Before approving a recommendation for residential care, assessment delegates first need to decide if an older person requires and is eligible to access this service group.

There is one key point to remember when deciding on access for older non-Aboriginal or Torres Strait Islander people. **Section 68** of the *Aged Care Act 2024* (the Act) requires these older people to have a continuing need for funded aged care services (including nursing) because of sickness in order to access the residential care service group. This requirement is also applicable to time-limited approvals including residential respite care. As an Assessment Delegate approving an individual for residential respite care assessment, they need to be satisfied that an older person's sickness at the time of the assessment means they have a continuing need for residential care including nursing services for a limited period of time.

Residential respite care is provided on a temporary basis within an approved residential care home. It is intended to give either the individual or their carer a short-term break from ongoing care responsibilities. Residential respite should only be recommended and accessed when there is a genuine short-term requirement for care. It is important to note that residential respite care is not a substitute for aged care rehabilitation or restorative care services.

Individuals approved for residential respite care are entitled to up to 63 days per financial year, with a possible 21-day extension under the *Aged Care Rules 2025*. These respite days do not need to be taken all at once and can be used flexibly throughout the year. Note that these timeframes do not apply where services are accessed under a specialist aged care program.

8.7.2. Step 2. Decide the classification level

When recommending an individual for residential respite care, assessors should complete the De Morton Mobility Index ‑ modified (DEMMI-modified) assessment. This tool assesses the individual's mobility and determines their eligibility for one of three respite funding classes: Respite class 1, Respite class 2, Respite class 3, based on the level of mobility observed.

The DEMMI-modified assessment is available within the IAT but can only be used as part of a Comprehensive Assessment, as it must be completed by a clinically trained assessor that has completed the DEMMI-modified training.

It is a Clinical Assessment Delegate’s responsibility to ensure that the DEMMI-modified has been accurately completed.

If the DEMMI-modified assessment cannot be completed at the time of assessment, the individual will be temporarily assigned a default funding class (Class 0). This classification remains in place until a formal Residential Aged Care funding assessment is carried out within the residential aged care home, at which point the appropriate funding class can be determined based on the individual’s assessed mobility.

8.7.3. Extensions for residential respite

Assessment Delegates may receive requests for a 21-day extension to residential respite care – for example, when a carer is unwell or temporarily unable to resume their care responsibilities. There is no limit to the number of extensions that may be granted beyond the standard 63 days of respite care per financial year.

Typically, the residential aged care provider submits the extension request via the My Aged Care Service and Support Portal, and an assessment organisation receives it through the Assessor Portal for an Assessment Delegate’s action.

It is the responsibility of the assessment delegate to review the request and either approve or decline it. Once a decision is made, the Assessment Delegate must communicate the outcome to the provider.

An assessment delegate will need to be satisfied that an increase in the number of respite days was necessary due to any of the following:

(a) carer stress

(b) severity of the individual’s condition

(c) absence of the individual’s carer

(d) any other relevant matter (for example, where a provider delivers an episode of respite care in good faith but subsequently finds out the care recipient's allocation of respite days had already been exhausted).

Please note, there is no right of review if an extension request is declined.

Once decided, you must give written notice to the registered provider of your decision whether to extend within 28 days after the application was made. This written notice must include the day the decision takes effect, which may be before the day the decision is made.

Extensions are granted only at the previously approved level of care. If a higher level is needed, a reassessment and new approval by you (or another Clinical Assessment Delegate) is required before the extension can be granted



Managing residential respite care | Australian Government Department of Health, Disability and Ageing

8.8. Approving transition care

8.8.1. Step 1. Decide if the older person requires transition care

Available following a hospital admission, transition care is delivered under the service groups of home support, assistive technology and residential care**.**

The Transition Care Program (TCP) is designed to support individuals in the period immediately after discharge from hospital. It aims to facilitate recovery, improve functional capacity, and provide time and support in a non-hospital environment while long-term care arrangements are being considered. The 'non-hospital environment' may be a home or community setting, or a residential care home.

Transition care and the Aged Care Act 2024

Before approving a recommendation for transition care, Assessment Delegates first need to decide if an older person requires and is eligible to access one of the relevant service groups.

Please note section 68 of the *Aged Care Act 2024* (the Act) (relating to 'people who are sick') applies to approving transition care in the same way it applies to approving residential respite care. Section 67 of the Act (relating to people who have a disability) also applies to approving people for transition care in the same way as it applies to approving people for home support (under the Support at Home program or CHSP) and assistive technology (under the AT-HM scheme or CHSP).

To access hospital transition care, an individual must first undergo an aged care needs assessment following a hospital admission. If it is decided they require and are eligible for hospital transition care, under the Act Assessment Delegates must approve them for:

- the classification type hospital transition for all three of the following service groups: home support, assistive technology and residential care

- the service type assistance with transition care under the home support service group
- all service types that can be delivered through the Transition Care Program, as specified in sections 50, 53 and 62 of the *Aged Care Rules 2025*
- the corresponding classification level for each of the service groups approved: *HS HT class* for home support, *AT HT class* for assistive technology and RC HT class for residential care.

If the support plan includes a recommendation for TCP, the Notice of Decision template the assessment delegate generates in the Assessor Portal will include wording covering all the required approvals listed above. The table below summarises the service group, classification type and classification level approvals given whenever an older person is approved for transition care through TCP.

Table 51. Summary of approvals under the Act for hospital transition care

Service group	Classification type	Classification level
Home Support	**Hospital transition**	HS HT class
Assistive technology	**Hospital transition**	AT HT class
Residential Care	**Hospital transition**	RC HT class

Access to transition care

Transition care is time-limited, with individuals allocated a funded period of 12 weeks to access services under the program. However, if the individual's recovery requires additional time, the service provider can apply for an extension.

The Transition Care Program is defined under the *Aged Care Act 2024* as a specialist aged care program. The number of places available for this care type is determined by the Minister, based on state and territory needs. Only registered providers are permitted to deliver hospital transition care using these allocated places.

Importantly, to be eligible for the program, the individual must be:

- medically stable at the time of assessment; and
- is in the concluding stage of a hospital episode; and
- has the potential to benefit from accessing services delivered through the relevant service group under the TCP; and
- at the time the assessment was carried out, a hospital inpatient.

It is an assessment delegate’s responsibility to confirm medical stability before approving access to the program.

Once an individual is approved for hospital transition care, it is usual practice for hospital discharge staff to refer them directly to their local Transition Care provider, following delegated approval.

Accessing residential care/residential respite and transition care

A person in permanent residential care who is receiving Transition Care must take Hospital Transition Leave for the duration of their TCP episode. In addition, they are not eligible to receive services under the Restorative Care Pathway under Support at Home.

An individual receiving Transition Care is unable to access residential respite care while Transition Care is in effect.

Duration of Transition Care

The standard period for a transition care episode is 12 weeks (84 days).

This period may be extended by 6 weeks, so the total transition care episode is 18 weeks (126 days) if the individual makes an application in accordance with the requirements of the Rules and is determined to require access to the services for the additional period.



Transition Care Program Guidelines | Australian Government Department of Health and Aged Care

8.8.2. Step 2. Record the decisions

When recording a decision to approve an individual for transition care, Assessment Delegates will be required to confirm a priority level for the care type. For transition care approvals, assessment delegates must ensure a priority level of ‘high’ is assigned to all approvals. This is a system requirement. Older people will continue to be able to access TCP services immediately and the priority category for TCP will appear in the NoD as n/a.

8.9. Other approvals and considerations

8.9.1. Alternative entry – giving approval after service commencement

Care, including urgent care, can be approved when assessment wasn’t possible prior to accessing those services. Section 71 outlines that an individual can be approved for services even if an assessment was unable to be conducted prior to accessing those services if the individual applies within the specified period under the *Aged Care Act 2024* (the Act) and the System Governor is satisfied that certain circumstances applied to the individual. Further information around this is detailed in Chapter 3: Referral, registration and screening.

If an assessment delegate is satisfied one of the alternative entry circumstances applies to an individual and that the other requirements under section 71 have been met, the Act allows the date of effect of approval to be set to the date care began. The Notice of Decision (approval letter) template includes wording to cover this scenario, to ensure that providers are paid from the beginning of service delivery. Delegates prompted by the system to enter a ‘Delegation date’ for their approval should always enter the actual day they make the decision, not the day when care began.

In most cases, individuals who have accessed a service prior to an assessment would have accessed this service through the My Aged Care contact centre urgent services pathway. Other circumstances may be emergency respite care and services provided by National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and Multi-Purpose Services Program (MPSP).

Services delivered before an assessment may not always be visible in the Notice of Decision (approval letter). Assessment delegates should always check the Support Plan in the Assessor Portal to view these services and be sure that they consider whether or not to approve these services.

Application process for people who have received aged care services and have not yet applied for an assessment under My Aged Care

NATSIFCAP and MPSP

Alternative entry pathways are available for individuals who commenced accessing specialist aged care services such as NATSIFACP and MPSP before an approval was given and at the time they were seeking access to services there was a significant delay in the availability of an approved needs assessor to conduct an assessment.

An application can be lodged for access to Commonwealth subsidised services under the Act's alternative entry provisions via any of the available application pathways (e.g. My Aged Care Contact Centre, Aged Care Specialist Officers online referral or self-referral through an Assessment Organisation). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 30 days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

Residential care or residential respite care

Alternative entry pathways are available for individuals who require urgent residential care or residential respite care. To be eligible, at the time they accessed this care, there must have been a significant risk of harm to the individual if those services were not delivered before approval to access funded aged care services was given.

An application can be lodged for access to residential care or residential respite care under the Act’s alternative entry provisions via any of the available application pathways (e.g. Contact Centre, online referral or self-referral through an Assessment Organisation) or by submitting the *Emergency Residential Care - Application for Care* form (see below). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 5 calendar days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

If completing the *Emergency Residential Care - Application for Care* form, the form must:

- have both the Emergency application section and the provider details section of the form completed; and
- The provider may submit the form, including supporting information for referral to their local assessment organisation, within 5 calendar days after the day care commenced unless an extension has been granted by the System Governor (on application).

If an older person and/or their active, active, appointed decision maker recognised under section 28 of the Act is unavailable, the registered provider may sign the form.

In urgent cases, the person is already receiving care, but this does not mean they are permanently entering aged care or will remain at the current facility.

If a provider prefers the older person's appointed decision maker to sign the form, they may apply for an extension. Under section 71 of the Act, an extension must be requested if the application cannot be submitted within the required timeframe.

Intake and assessment process for an Emergency Residential Care – Application for Care

When the form is received, the assessment organisation must:

- Ensure the form is signed by the older person, or their active, appointed decision maker recognised under the Act, and confirm the *emergency case* section is completed correctly by the registered provider.
- Confirm the date the form was received. If it was submitted after 5 calendar days from the care start date, assessment can only proceed if the provider has been granted an extension by the System Governor, following an application for extension.
- Register and self-refer the older person in the My Aged Care Assessor Portal (if required and self-referral criteria are met).
- Assign intake priority. Although the person is already in care, the triage delegate must consider the urgency of the individual's circumstances. If the person's condition is rapidly deteriorating, the assessment should be scheduled as soon as possible.
- Upload the verified form to the older person's record.
- Schedule a comprehensive assessment with an assessor. Where possible, this should be face-to-face and collect information to:
  - Determine the older person's required level of care; and
  - Confirm that urgent circumstances existed at entry and that prior approval was not practicable.
- Record the Emergency Care start date (for residential care or residential respite) before sending to the assessment delegate.
- The assessor must collect as much information as possible about the urgent situation from the older person, their registered supporters (if available, and in line with the older person's will and preferences), their active, appointed decision maker/s (as relevant), the registered provider, and any other professionals involved at the time of entry.

Making a decision about alternative entry

Assessment delegates are responsible for determining whether an older person who commenced care before applying for approval can be approved under alternative entry. To do this, they must ensure that the application process meets all relevant requirements described in this content, including, that the older person is eligible for the type of care being provided, and that the care was urgently needed at the time it began. Assessment delegates must also be satisfied that it was not practicable to obtain approval before the care commenced (see circumstances described above). The decision must be based primarily on the care needs of the older person at the time they entered care.

If care is approved under urgent circumstances, an assessor will need to update the My Aged Care assessor portal. This includes checking the *Emergency Care* flag and recording the date the older person entered care. Doing so ensures the registered provider receives the appropriate Commonwealth subsidy from the correct start date. An assessor will also

send the referral to the provider via the portal, allowing them to access the older person's record and view all relevant approval details.

Assessment delegates should also be aware that this process applies in cases where the assessment has been completed but the older person passes away before a decision is made.

Not all circumstances qualify as urgent. Situations such as a bed becoming available in a residential aged care facility, or a transfer from an acute care setting to another care environment, do not meet the criteria for urgent admission.

If an assessment delegate determines that the older person did not urgently require care at the time of entry, but they are otherwise eligible, the application can still be approved, however the date of effect will be the date you make the decision.

The decision about whether to approve alternative entry dates for an older person is a **reviewable decision** under section 557 of the *Aged Care Act 2024.*

Assessment delegates are required to record their justification for approving under alternative entry so that there is clear evidence of a person meeting one of the requirements under section 71.



Extensions

While it is best practice for providers to submit the *Emergency Residential Care - Application for Care* form−complete with the emergency case section−within the required timeframes of the older person entering care, the *Aged Care Act 2024* allows an application for an extension of time under section 71 if this is not possible.

If the form is not signed and submitted within the required 5 calendar day timeframe, it is considered incomplete. In this case, the registered provider must first apply to the System Governor for an extension The delegation for granting extensions for those seeking access to funded aged care services through alternative entry will sit outside Assessment Organisations.

In considering an extension the System Governor will either decide to:

- Approve the application and determine a longer period for the individual, or
- Reject the application

As soon as practicable after a decision has been made, the System Governor must provide notice of their decision. Included in the notice will be the reasons for the decision and how to apply for a reconsideration of the decision.

Where the older person has not made their application in the required timeframe, an extension may be granted by the department. In these instances, providers should email a request for an extension to MyAgedCare.Assessments@health.gov.au. Please include a brief explanation on the reason for the extension.

If an assessor believes the older person urgently needed care but the approval is already recorded in My Aged Care with a later date, they must initiate the **corrections process** to backdate the approval. If the required backdating exceeds **42 days**, a correction cannot be made, and a reassessment is required.

8.9.2. Exceptional circumstances – approving a service without an assessment

In some circumstances, under section 65(4) of the *Aged Care Act 2024* a client may be approved to access aged care services without undergoing an aged care needs assessment owing to exceptional circumstances. This will typically occur where a person is accessing funded aged care services through the alternative entry pathway but pass away prior to receiving an assessment.

In a case where the older person has passed away, assessors should follow the *Client Deceased Before Assessment* process available through the My Aged Care assessor portal. This ensures the approval is properly recorded in the system and automatically submitted to **Services Australia**.

If there are complications preventing the use of the online process, an assessor should consult their Team Leader for advice. Do not cancel the assessment in My Aged Care using the reason ‘client deceased.’ This action changes the older person’s status to ‘deceased’ and locks the record as read-only, preventing an assessment delegate from recording an assessment decision.

If the record has already been locked, the assessor must contact the My Aged Care Service Provider and Assessor Helpline (1800 836 799) to temporarily reactivate the record so the assessment outcome can be recorded. Once the decision is entered, the status must then be changed back to ‘deceased’ to reflect the older person’s passing.

Client is receiving services but is refusing an assessment

If the Triage delegate or assessor consider there are valid reasons for the person refusing to have an assessment, assessment organisations are to contact the department in the first instance at MyAgedCareAssessment@health.gov.au for assistance. In some cases, the department may exercise delegation to approve services under the exceptional circumstances provision.

9. Chapter 9: Finalising the assessment and service referral

What you'll find in this chapter

This chapter includes guidance about:

- finalising the assessment
- recording and communicating the assessment outcome
- referring the older person for services, and supporting them to access services
- the single provider model for Support at Home (which includes a single referral code for all services/pathways)
- completing the Notice of Decision (approval/non-approval letter).

9.1. Overview of assessment finalisation

An assessment is finalised when:

- the assessment and support plan are completed; and
- all required decisions have been made and recorded by the Assessment Delegate; and
- when effective referrals have been made or the older person has decided not to proceed with accessing aged care services, and
- the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) has been notified of the assessment outcome.

An effective referral is where:

- a referral is accepted by a service provider who can deliver a service response consistent with the relevant service recommendations on the older person's Support Plan, **or**
- the older person has accepted responsibility for managing their own referral(s) through a referral code, **or**
- the outcome of the assessment is that no further action is required by the assessor; **or**
- the assessor has made all available and reasonable efforts to connect the older person with a service provider appropriate to their assessed care needs.

For older Aboriginal and Torres Strait Islander people, FNAO assessors may facilitate the client's entry into aged care or refer the client to an Elder Care Support worker to assist the client to connect with services after the assessment is finalised.

When the Support Plan is finalised and an effective referral has been made, the assessor should inform the older person to contact their provider, ECS worker or the My Aged Care contact centre if there is a future change in needs, goals, or preferences. If within their remit, the My Aged Care contact centre will assist the older person with their enquiry. This could include re-issuing a referral code or if a referral is rejected, sending a referral to another provider. The contact centre or the provider can send a support plan review request to the assessment organisation if it is an appropriate request.

Where appropriate, assessors are encouraged to follow up vulnerable or at-risk older people post-assessment who:

- have referrals that have been rejected/not actioned - this may include the monitoring of referrals to services or negotiating with service providers for the provision of alternative services if necessary,
- are working on short-term reablement goal(s) – in line with the length of time stipulated in the Support Plan, and/or
- are vulnerable older people, as determined by complexity indicators or need for linking support and required short-term linking assistance purpose of implementing the Support Plan.

After finalising the assessment, where the department becomes aware that an older person is having difficulty with accessing services, an assessment organisation may be required to follow up with the older person or service provider and provide advice on any follow-up action/s taken.

9.2. Setting the access approval date of effect ('delegation date')

For an older person's application, the access approval date of effect that Assessment Delegates decide applies to all of the following decisions under section 65 of the *Aged Care Act 2024* (the Act):

- the service groups, and the classification types for those service groups
- the service types (and services if applicable).

Assessment Delegates record this date in the Assessor Portal after giving responses to all of the care recommendations. In the 'Save decision and delegate' popup, the Delegate should enter the day that they are making the decision (that is, that day's date) and click 'Save decision.' Note that even if the older person has received services before assessment (using the alternative entry provisions under Section 71 of the Act), the Assessment Delegate should still enter the date the decision is made - not an earlier date.

There is wording in the Notice of Decision (approval letter) relating to alternative entry scenarios and the access approval date of effect.

For emergency residential care or residential respite, the assessor is required to record the date care began through the "Emergency Care Start Date" flag in the Integrated Assessment Tool. This date will allow the service provider to claim for the days prior to the delegation start date. The Assessment Delegate should check this to ensure that the correct date is recorded in this field before proceeding with their decision.

9.3. Recording and communicating the assessment outcome

A critical record of the assessment outcome is the Notice of Decision (NoD). Note that the NoD is referred to as the 'assessment outcome letter' in materials and website content for older people and is labelled as the 'approval/non-approval letter' in the assessor portal.

The older person (and registered supporter/s and/or appointed decision maker/s, if applicable) should be sent the following documents:

- the NoD
- the finalised Support Plan
- the referral code letter (at a minimum for older people who have been approved for CHSP services)
- NoD attachments for NoD Approval letters with a home support outcome
- any relevant aged care consumer information not provided at the time of the assessment
- the older person satisfaction survey of the organisation's performance requirements
- other associated notification documents.

The assessor must:

- call the older person once the NoD is finalised to notify them that their assessment has been completed (where needed, FNAO assessors may also explain the letter to the older Aboriginal and Torres Strait Islander client)
- advise the older person that their Support Plan and NoD can be accessed via their My Aged Care Online Account (under 'documents' and 'plans' for the Support Plan) and their My Health Record (if the older person has consented)
- advise the client that if they have provided consent, their registered supporter/s are able to access these documents (via their own separate login information) to the client portal
- advise the initial referral source of the assessment outcome and referral outcome - if requested by the referrer and with the consent of the older person.

While it is considered good practice to offer an older person a hard copy of their Support Plan and relevant information, where this is not feasible for an assessment organisation, the minimum requirement is that the older person, and where relevant, registered supporter:

- is clear on what is in their finalised Support Plan and are agreeable to this and which associated people it will be shared with,
- agrees to be provided a soft copy of the finalised Support Plan and if appropriate the referral code letter (noting that older people will receive a letter once they have been assigned a package), and/or
- is aware of how to obtain a copy of the Support Plan and relevant information via their My Aged Care Online Account.

9.3.1. Notice of Decision of assessment outcome

Assessment Delegates are required under the *Aged Care Act 2024* (the Act) to issue a Notice of Decision (NoD) to the individual within 14 days of making a decision under subsection 65(1) or (2).

This supports the Act's rights-based approach by promoting transparency, accountability, and informed decision-making, and by ensuring individuals understand decisions that affect their care and access to aged care services.

The NoD must clearly communicate:

- the assessment outcome, including decisions to approve or not to approve access to services,
- the reasons for these decisions, and
- how the individual may apply for a review of the decision(s).

NoD requirements under the Act

For assessment delegates to meet their obligations under the Act, they must ensure that the notice sent to the individual satisfies the requirements of the Act. Assessment delegates can generate NoD templates in the Assessor Portal with most of the critical information pre-populated and which also includes guidance on how to complete a legally compliant letter. The NoDs must satisfy the requirements in the following sections of the Act:

- **Section 70:** notify the individual about the decision regarding their access approval, including information on the approved service group(s), and the classification type(s) for the service group(s), any service types, and funded aged care services, and the date the access approval takes effect. The reasoning behind the decision and how the older person can apply for a review of decision, if necessary, must also be clearly explained. The 'About the decisions: Reasons and Review Options' section in the NoD gives more information on what must be considered and included in the reasons.
- **Section 79**: inform the individual about the classification decision, including the classification level(s) for the approved service group(s), and when the classification level(s) did or will come into effect, and how they can apply for reconsideration if necessary.
- **Section 88:** If necessary, notify the individual about any priority category assigned to a classification type for a service group, clearly explaining the reasoning behind the decision and how they can apply for reconsideration if necessary. This is necessary in the scenarios listed in the table below.

Service group	**Classification type**
Home support	Ongoing (except when the classification level is 'CHSP class')
Assistive technology	Ongoing Short-term
Home modifications	Short-term
Residential care	Ongoing

- **Section 92(4):** If necessary, inform the individual of any place they have been allocated, and the day the allocation of the place takes effect.

When is a NoD required?

A NoD must be issued following an initial assessment, reassessment, and (in most cases) a support plan review (SPR). A NoD is required after all SPRs, except when the SPR:

- leads to a referral for a full reassessment, or

- only approves a second concurrent unit of funding for the Restorative Care Pathway[7], or
- transitions the person back to a previously approved ongoing Support at Home classification after an End-of-Life Pathway finishes, or
- is adding a service that is within a service type[8] that has already been approved *from the perspective of the Act*[9] unless the service is within one of the prescribed service types ('Allied health and therapy' or 'Therapeutic services for independent living').

Triage, alternative entry provisions and the NoD

If the older person does not meet eligibility requirements to receive an aged care needs assessment under Section 58 of the Act (i.e., at triage), the triage delegate should prepare a **Notice of Decision – Not eligible for assessment** letter and complete it in line with the instructions within the letter.

If a triage delegate makes a referral for urgent services through the alternative entry provisions under Section 71 of the Act (refer to section 3.2 of this manual), they do not need to generate a NoD at that point in the process. Once the assessment is complete, the assessment delegate will generate the NoD covering approvals for these services.

If the older person does not meet the eligibility requirements under Section 65 of the Act, they are not eligible to receive the service provided through an alternative entry pathway under section 71 of the Act. The assessment delegate must apply the Act's eligibility criteria when making their decision and, if required, not approve the service at the time of assessment.

9.3.2. Notice of Decision templates

NoD templates can be generated in the My Aged Care Assessor Portal after assessment delegate decisions have been made and recorded. Much of the critical information is pre-populated and the templates include detailed guidance on how to complete a legally compliant letter.

There are two NoD templates:

i. **Approval letter**:
   - Used when the Assessment Delegate is approving access to any services – even if some of the services recommended have not been approved.

ii. **Non-approval letter**:
   - Used after initial assessment, when the assessment delegate is not approving the older person for access to *any services at all.*
   - After Reassessment or SPR when the assessment delegate is not approving the older person to access *any additional services.*

[7] A separate letter is required in this instance – see section 9.3.2 below for more information
[8] The Aged Care Service List in Chapter 1, Part 3 of the *Aged Care Rules 2025* lists all the service types and services
[9]The older person's Support Plan may not list all of the services the older person is actually approved for under the Act. For example, if the older person's support plan shows they are only approved for the service 'Laundry services', they are actually approved under the Act for *all* the services in the service type 'Domestic assistance' – including 'General house cleaning' and 'shopping assistance'.

If a reassessment does not add any new approvals and existing approvals remain unchanged, the system will prompt the delegate to generate a non-approval letter only. This does not affect the client's current approvals. The non-approval letter simply confirms that no additional services were approved during the reassessment or a SPR.

Refer to section 9.3.6 for details on the approval letter for a second unit of RCP.

9.3.3. Completing an NoD

To ensure the NoD is tailored to the individual and includes all required legal information, assessment delegates must:

- generate the letter from the My Aged Care Assessor Portal
- save the letter locally and make the necessary edits following the guidance text in the template
- clearly set out the reasons for their decisions (see following sections for further guidance)
- include the Commonwealth Coat of Arms and the My Aged Care logo
- **not** include any co-branding – logos of individual assessment organisations must not be included, as specified in the contractual agreements between the Department and individual assessment organisations.

To ensure the NoDs remain legally compliant, assessment delegates must follow the guidance provided in the Notice of Decision templates and associated departmental guidance materials.

Assessment delegates may only remove or amend text where explicitly directed by the department.

9.3.4. Reasons for decisions

Assessment delegates must consider and record reasons for approval and non-approval decisions relating to service groups, service types or services. Assessment delegates must turn their mind to these reasons when making approval decisions and then record them in the NoD.

Delegate decision reasons must:

- demonstrate how the individual meets or does not meet the criteria for approval under the relevant sections 65–68 of the *Aged Care Act 2024* (the Act),
- be tailored to the person's specific circumstances, drawing on the information provided in the IAT, support plan and assessment report,
- clearly explain (for approvals) how the individual satisfies the relevant eligibility criteria under the Act and the rules, with reference to their unique situation.
- The NoD templates provide detailed guidance on how to record reasons that fulfil these requirements. Chapter 8 provides a comprehensive explanation of the eligibility requirements set out under sections 65-68 of the Act and the relevant rules.

For a comprehensive explanation of the eligibility requirements set out in sections 65–68 of the Act, the relevant rules, and guidance on which reasons apply, refer to:

- Section 7.6 'Delegate decisions under the *Aged Care Act 2024'* of *Aged Care Assessment Manual v8.3*

The NoD templates provide detailed guidance on how to record reasons that fulfil these requirements. All reasons included must be relevant, accurate, and clearly linked to the decision made. Assessment delegates must not draft their own reasons or edit the wording of prescribed reasons. Assessment delegates must only amend the reasons section where directed in the template or by the Department.

Reasons for decisions: approvals

Reasons for approval decisions are recorded in NoD approval letter. The reasons for decision for approval outcomes are automated in the template. The templates will:

- automatically pre-select a set of 'likely reasons' based on the approvals recorded in the system.
- include a list of 'other possible reasons' for the delegate to consider.

The system will automatically generate a list of **likely reasons**. Any reasons that do not meet these criteria will be included in a secondary list as **other possible reasons** for consideration.

Reasons for decisions: non-approval

If one or more approvals were recommended by the assessor and/or requested by the older person but were **not** approved, an assessment delegate must provide reasons why they did not to approve access to the service group, service type or service. Relevant situations are summarised in the following table.

Table 52. Summary of situations relevant to non-approval of recommended and/or requested approvals

Situation	Applicable Notice of Decision template
An initial assessment or reassessment/Support Plan Review where some of the services recommended or requested have not been approved (while others have been approved).	**Approval Letter**
A first assessment where the older person has been found ineligible to access to any services. A reassessment/Support Plan Review where no **additional** services have been approved.	**Non-Approval Letter**

For non-approval reasons an assessment delegate must: consider how the individual's circumstances relate to all the relevant eligibility criteria set out in the *Aged Care Act 2024* and the *Aged Care Rules 2025* for the particular service.

For an older person to be considered eligible for a particular service group, service type etc, an assessment delegate must be satisfied that **all** of the relevant eligibility criteria apply. If they do not meet all of the criteria – they cannot be approved.

The assessment delegate must use the free text sections in the NoD template to provide a brief summary of the reasons why the older person does not meet the eligibility criteria.

An assessment delegate must refer to the individual's unique circumstances and information in the assessment report (support plan). The assessment delegate must include details of how the individual's circumstances related to the eligibility criteria and therefore informed the decision not to approve.

The instructions in the NoD templates prompt the delegate when free text description is required.

Reasons for decision – Transition Care Program

An approval for TCP is an approval for three service groups under the Act: home support, assistive technology and residential care. An approval for TCP is always an approval for all three service groups, regardless of which TCP services are used. The NoD will automatically populate the required reasons for decision sections.

The system generated NoD templates account for the scenarios that are most likely to occur in practice. If the Assessment Delegate encounters a scenario that is not covered in the template, their Operational Manager can contact the department at myagedcare.assessment@health.gov.au for further guidance

9.3.5. Uploading and sending the NoD

Once the NoD letter is finalised and signed, assessment delegates must upload it to the assessor portal (all documents must be uploaded in PDF format) for record-keeping purposes, and then post, email, or notify the individual the NoD is available via the MAC online portal (and their registered supporter/s and/or appointed decision maker/s, if applicable) using their preferred communication method/s.

> Important:
>
> The Support Plan needs to be included as an attachment whenever the NoD is sent. The Support Plan lists any approved service types and services, so it is legally considered part of the NoD.
>
> The Referral Code letter also needs to be attached whenever approvals for CHSP services are given.
>
> **NoD attachments**: If the client receives a NoD Approval letter for ongoing home support, include **NoD Attachment 1**. If the client identifies as **Aboriginal and/or Torres Strait Islander** and receives a NoD Approval letter for ongoing home support, include **both NoD Attachment 1 and NoD Attachment 2**. Ensure the relevant attachments are included, as they provide additional information that supports and complements the Notice of Decision Approval letter. The attachments are available on the Department's website (see below for links).
>
> Providers can view the NoD and support plan via the My Aged Care Service and Support Portal.
>
> Older people can also view their NoD, Support Plan and Referral Code letter (for CHSP approvals) via their My Aged Care Online Account. An older person's registered supporter/s (if any) may also be authorised to access this information.

Where an assessment delegate determines that no funded aged care services are required, the delegate will also need to send a NoD to the older person to formally advise them of this outcome.

> Note**:**
>
> Older people who request/are recommended for the End-of-Life Pathway but are not approved *do not* receive a 'Non-approval letter.'



NoD Attachment 1

NoD Attachment 2

NoD delivery time frame

The Act requires the NoD to be given to the individual within 14 days of the delegate's decision.

To mitigate potential issues in meeting the timeframe for giving the notice, assessment delegates should:

- obtain agreement of the older person for **electronic delivery** of notices (email or portal) where possible
- upload the NoD promptly to the client's **My Aged Care Online Account**
- confirm client and supporter contact details before dispatch and send the notice as soon as possible to the designated postal or email address

Postal delays are outside the control of assessment organisations. Where a notice is to be given by post, **Assessment Delegates must**:

- send the notice as soon as possible by **pre-paid post**, properly addressed to the individual at their **last known postal address**, and
- **record the date** on which the notice was sent.

Requirements for electronic delivery

When the notice is provided to the client via their My Aged Care Online Account the assessment delegate must notify the client that the notice has been uploaded and can be retrieved. Delegates should use the notes tab on the client's record to document that this notification has occurred and the date it happened.

If providing the notice electronically to an address that has not been designated by the client, the notice is given when it is capable of being retrieved. Assessment delegates should clearly communicate to a client which address the notice has been provided to so it can be retrieved within the 14-day period.

Note: If a client is unable to readily access their emails or My Aged Care Online Account, the notice **must be sent via pre-paid post**. Assessment Delegates should confirm this with the client when obtaining their agreement for electronic delivery of the notice.

9.3.6. Notice of outcome of application for second concurrent unit of restorative care funding

If a support plan review is being conducted and a second concurrent unit of restorative care funding has been requested, a letter must be sent to the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) notifying them of the outcome of the application for the additional funding.

The decision to approve additional funding to the Restorative Care Pathway episode is made under section 195-3 of the *Aged Care Rules 2025.*

The Approval for RCP second unit of funding letter can be generated via the portal the same way as the NoD Approval and Non-approval letters are generated.

When the outcome of the support plan review for a second concurrent unit of restorative care funding is not approved, the notice needs to be updated using the appropriate template which can be found under the 'Forms' tab in 'Reports and Documents' tile in the Assessor Portal.

Once finalised, the letter must be signed and uploaded to the assessor portal for record-keeping purposes, and then post or email it to the individual (and their registered supporter/s and/or appointed decision maker/s, if applicable) using their preferred communication method/s.

9.3.7. Registered supporters who are authorised to receive copies of letters

If an older person has a registered supporter/s who is authorised to automatically receive certain information or documents about an older person, they must be given a copy of the information or document. Registered supporters can access these documents if they have arranged their own login to the client portal via My Aged Care. If an older person has multiple registered supporters who are all authorised to receive copies of an information or document, each registered supporter must receive a copy. This includes a Notice of Decision.

Section 29 of the *Aged Care Act 2024* (the Act) provides that any information or document that is required or authorised under, or for the purposes of, the Act to be given to an older person must also be given to their registered supporters if:

- the older person has consented to sharing this kind of information with their registered supporter, or
- regardless of whether the older person has consented, the registered supporter is a person covered by subsection 28(2) of the Act. That is, they are a registered supporter who relied on their authority as an active appointed decision-maker for the older person in becoming registered.

These registered supporters are called 'supporters' and 'supporter guardians' in the assessor portal and app.

A registered supporter who is recorded as a 'supporter lite' cannot automatically be given information or documents about an older person. This is because the older person has not consented to that registered supporter receiving their information and documents under section 29 or the registered supporter is not a person covered by subsection 28(2) of the Act. That is, they are not a registered supporter who relied on their authority as an active appointed decision-maker for the older person to become registered as a supporter.

For example, assessors must not send a supporter lite a Notice of Decision. If a request has been made by a supporter lite to access a Notice of Decision letter, this should be escalated to the departmental team responsible for supporters.

9.3.8. Using electronic signatures

Under Section 10 of the *Electronic Transactions Act 1999*, electronic signatures can be used when a Commonwealth law requires a person's signature. Assessment Delegates can use an electronic signature instead of a handwritten one.

However, before using an electronic signature, Assessment Delegates need to make sure that all legal requirements have been met under Section 10 of the Electronic Transactions Act 1999.

To do this effectively, follow these practices:

1. **Monitoring Use:** Set up procedures to track when their electronic signature is applied, so Assessment Delegates are always aware of its use.
2. **Administrative Assistance:** Assessment Delegates can get help from administrative staff to attach their electronic signature, but they should remember that the final responsibility for the notification remains with the Assessment Delegate. Administrative staff do not have the authority to apply the signature on their own.

Acceptable forms for an electronic signature include a typed name, personal mark, signature image, personal email, clicking an 'I accept' box, or using a digital signing platform, provided they clearly demonstrate the person's identity and intention. Please see link below for further advice from the Attorney-General's Department regarding types of electronic signatures that can be used.



Electronic Transactions Act 1999

Attorney-General's Department - Types of electronic signatures that can be used

9.4. Referral and support for service access

9.4.1. Referral codes

A referral code is a unique reference number used to connect an older person with a provider, enabling them to begin receiving services. Referral codes will be generated at different stages and through different mechanisms depending on the program recommended during the aged care needs assessment.

9.4.2. When to share referral codes

From 1 November 2025, all Australian government-funded aged care services fall under the *Aged Care Act 2024*. This includes CHSP services, which were not under the *Aged Care Act 1997*. This means that for all service approvals (including for CHSP), **referral codes cannot be issued to the older person or service providers until the Assessment Delegate has completed and signed a Notice of Decision.**

This is an important change that assessment organisations must adhere to, to ensure compliance with the *Aged Care Act 2024*. If referral codes are given to the older person

and/or provider(s) and a Notice of Decision is ultimately *not* issued, risks invalidating the assessment outcome. The Notice of Decision is the key legal mechanism that records a decision by the System Governor for the client to receive a funded aged care service.

The Notice of Decision does **not** include the referral code(s) for the recommended service(s). Referral codes displayed in the Support Plan can be used to reach out to as many service providers as preferred. The Support Plan must be sent as an attachment to the Notice of Decision. For CHSP service referrals, the referral code letter must also be sent as an attachment to the Notice of Decision.

> Note: Providers should not be asking older people to provide them with a copy of the Notice of Decision (NoD). Team leaders in service provider organisations are able to access the NoD through the Provider Portal both before and after accepting the referral.

9.4.3. Generating referrals/recommendations

An assessor must ensure that older people are referred to service providers according to service availability and the older person's needs and preferences. The assessor should ensure they have delegate approval prior to issuing a referral.

Assessors may send referrals electronically to one or more government-funded service providers of the older person's choice or provide the older person with a referral code for the older person to self-manage the referral. The client can also ask for the code to be broadcast to several local providers to find availability.

Prior to sending the referral, the assessor must ensure that the older person (or their appointed decision maker recognised under the Act, regardless of whether they are a registered supporter):

- consents to the My Aged Care referral method (broadcast, preference, or referral code)
- consents to the department providing information from the older person's My Aged Care online account to the provider for the purposes of the provider actioning the referral (including to provide the agreed service recommendation on the Support Plan.

9.4.4. Support at Home referrals

A single provider will oversee and deliver all Support at Home services (including ongoing services, short-term services through the Restorative Care Pathway, End-of-Life Pathway and AT-HM scheme) for a participant.

Under this model, registered providers will be required to hold registration that covers all services the participant will receive.

> Note: Some providers may not be able to deliver all services a participant needs. Providers can choose to engage a third-party (associated provider) to deliver services on their behalf, however the provider remains responsible for delivery of services and compliance with relevant obligations.

If an older person prefers a particular service provider who does not have availability, the older person can elect to be referred to that service provider's waitlist on the system (if a waitlist is available). Older people can be on multiple waitlists at any one time.

A participant can change Support at Home providers at any time. Once a participant has chosen their provider, the provider will receive a referral in the My Aged Care Service and Support Portal.

Where a service provider is not available to meet the needs of the older person and the older person does not want to be put on a waitlist, the assessor should have a further conversation with the older person to consider other alternative options for support. Other options may include:

- a different service provider that could meet the need (on an interim or ongoing basis)
- non-Commonwealth-funded services; or
- the older person and/or their carer, registered supporter or other person who supports the older person being able to address their need.

Where required, the assessor is to provide short-term assistance to the older person for the purpose of implementing the Support Plan. This may include monitoring referrals or discussing options with service providers for the provision of alternative services if necessary, or in cases of providing for vulnerable older people, linking support or care coordination.

Referrals for Restorative Care Pathway, the AT-HM scheme and End-of-Life Pathway

If a participant receiving ongoing Support at Home services is referred to a short-term pathway (Restorative Care, the AT-HM scheme and End-of-Life), and their current registered provider does not deliver services under these pathways, the participant will be required to change providers to access their short-term pathway.

Assessors should ensure the individual is aware of this and confirm referral needs with the individual.

 For further information see the Support at Home Program Manual.

Support at Home referral codes

The same referral code will be issued for every Support at Home (SaH) classification level (this includes ongoing and short-term services). This referral code will apply to all services approved under that classification level. The older person can present the referral code directly to their preferred provider or alternatively they can request assistance from the contact centre or the assessor for assistance in issuing a referral to a provider(s).

Referral codes are not listed in the Notice of Decision letter. Referral codes are generated and listed in the support plan in circumstances where a referral code is needed.

For an individual approved for an ongoing SaH classification or AT-HM, the referral code is generated once the individual has been allocated a place (and therefore funding) through the Support at Home, Assistive Technology or Home Modifications Priority Systems. A separate Funding Assignment Notice with the corresponding referral code will be sent to the older person.

In circumstances where a participant is already receiving services from a SaH provider (for example, moving from the End-of-Life Pathway back to ongoing services), a referral code is not generated. In these circumstances a referral code is not required as the connection with a provider and access to the participant's record is already established through the initial use of the referral code.

For new Support at Home participants approved for the End-of-Life Pathway or Restorative Care Pathway:

- if a service referral has been made, the provider will contact the participant
- if no service referral has been made, the referral code will be displayed in the support plan.

If a participant is already receiving services and wants to change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code, enabling it to be used to connect with a new provider. Alternatively, if the participant indicates during their assessment that they want to change providers and have the assessor make the service referral, the referral code can be found in the assessor portal.



9.4.5. CHSP referrals

Assessors cannot issue CHSP referral codes until *after* the assessment delegate has approved the recommendation.

Multiple referral codes

For CHSP services, a Support Plan may contain recommendations for multiple services within the same service type (e.g. Laundry, General House Cleaning and Shopping assistance services under the Domestic Assistance service type).

The assessor will need to generate a separate referral code for each service type and service recommended. This is necessary because not every CHSP provider can offer all services, so **codes for each service under each service type are needed** to ensure clients have access to all recommended services.

Assessors should ensure the client's needs are **fully considered** when making service recommendations and that all relevant referrals are completed at the time of the assessment. For example:

- If a client is assessed as needing Occupational Therapy, the assessor should also consider whether equipment is required to support safety at home and, if needed, issue the appropriate referral for equipment and products.
- If a client is recommended for Group social support, the assessor should also consider whether they require transport to attend the group centre.
- This means the client does not need to request an SPR for any additional service referrals they require.

If a service aligns with the older person's assessed needs and goals, assessors can issue more than one referral code for the same service type – allowing the person to access two services from two different providers.

For example:

- if an older person wishes to access services under the Social Support and community engagement service type from two different providers (e.g. individual

social support and group social support), **the assessor should create two separate** service recommendations using the 'Add a service recommendation' function. Each recommendation will generate a distinct referral code, ensuring that each provider receives a unique referral code
- Allied Health and Therapy services and Therapeutic Services for independent living service types - the assessor should always generate a separate referral code for each service recommended such as Physiotherapy and Occupational Therapy.

Reissuing CHSP referrals – Grandfathered CHSP clients

Certain CHSP clients were 'grandfathered' into the CHSP with service referrals but have not undergone an assessment through My Aged Care.

- These referrals are not valid under the *Aged Care Act 2024*.
- These clients must undergo an aged care assessment to comply with the Act.
- If found eligible, assessors must **generate new referrals** for any CHSP services that are approved following an assessment and delegate approval.

Reissuing CHSP referrals following Urgent services

All clients who have accessed urgent services must complete an assessment, *and* new referrals must be generated for any approved ongoing CHSP services.

- CHSP providers will continue to deliver urgent services until an assessment is completed. Post assessment, the Assessment Delegate will determine whether the urgent services are approved.
- When ongoing CHSP services are approved, the *urgent service referral should end*.
- **New CHSP referrals are required** for the provider to continue delivering services on an ongoing basis.
- Where a delegate **does not approve** the urgent service:
    - If the service has not commenced, the direct-to-provider referral may be recalled.
    - If the service has commenced, the provider will be notified that the urgent service is not approved and should cease urgent service provision.

9.4.6. Residential care referrals

For residential care (including through Multi-Purpose Service Program (MPSP), the assessor can issue a referral code following the assessment and approval of services to enable the older person to take time to look for a suitable residential facility. Referral codes are contained within the client's support plan.

When selecting a residential aged care service provider to issue a referral to, assessors can use Star Ratings to help compare the quality of aged care facilities (not applicable for MSPS and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)). Star Ratings are available via the 'Find a provider' tool on the My Aged Care website. All aged care facilities receive an overall Star Rating and ratings against Compliance, Residents' Experience, Staffing and Quality Measures).

Assessors can share a client's referral code with as many providers as the client chooses. A provider will use the referral code to view the client's approved services and specific needs in the service and support portal. If the provider and client agree they will take a bed in the residential care home, a formal agreement will be exchanged between the parties, and

the referral will be formally accepted in the My Aged Care portal. Once a provider accepts a referral and payments commence from Services Australia, all other open referrals will close.

My Aged Care - 'Find a provider' tool

9.4.7. Generation of referral codes for different programs and pathways

The table below provides further details regarding referral codes across the different approval pathways and programs.

Table 53. Guide for generation of referral codes for aged care programs

Aged care program	Pathways	Generation of a referral code
Support at Home program	SaH ongoing	Once the older person is allocated a place through the Support at Home Priority System, they will be sent a funding assignment letter containing their recommended services and the referral code for ongoing SaH services classifications 1 - 8. If a participant is reassessed to a higher ongoing classification the upgrade notice letter will contain a referral code. However, the participant does not need to take any action as the referral code will already be active with their provider. To change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code which can then be used to connect with a new provider. This follows the same pathway previously used in the Home Care Packages Program. Note: If the older person has previously been approved for the End-of-Life Pathway, a referral code is not generated
Support at Home	End-of-Life Pathway (EoL)	Referral code is generated into the Support Plan attachment provided to clients (if no service referral has been made AND the older person has not been approved for an ongoing Support at Home classification previously)
Support at Home	Restorative Care Pathway (RCP)	Referral code is generated into the Support Plan attachment provided to clients (if no service referral has been made and the older person has

Aged care program	Pathways	Generation of a referral code
		not been approved for an ongoing Support at Home classification previously). **Note:** If the current provider does not provide Restorative Care the older person will need to change providers. To change providers, they will need to contact the My Aged Care Contact Centre to reactivate their referral code which can then be used to connect with a new provider.
Support at Home	Assistive Technology and Home Modifications (AT-HM) scheme	Once the older person is allocated a place through the Assistive Technology and/or Home Modifications priority system/s, they will be sent a funding assignment letter containing their recommended services and the referral code for their AT and/or HM classifications. This is the same referral code used for SaH ongoing, EoL and RCP classifications. If the participant is already receiving services from a Support at Home provider, they do not need to take any action as the referral code will already be active with their provider. Note: For the below circumstances, where AT-HM funding is allocated immediately, the participant does not receive a funding assignment letter. 1. Approval for a higher AT or HM short-term tier through an SPR. If the participant is not already receiving services from a Support at Home provider, the referral code is generated into the Support Plan attachment.

Aged care program	Pathways	Generation of a referral code
Commonwealth Home Support Program (CHSP) National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) Multi-Purpose Service Program (MPSP)	CHSP, NATSIFACP and MPSP services will require assessment, delegate approval, and a Notice of Decision (letter outlining their decision) to be issued. The Support plan attachment provided to clients will include the referral code(s) for CHSP, MPSP and NATSIFACP (if no service referral has yet been made). For CHSP services, a Support Plan may contain recommendations for multiple services within the same service type (e.g. Laundry services, Shopping assistance and General house cleaning under the CHSP Domestic Assistance service type) **Note:** Allied health and therapy services and Therapeutic services for independent living Service types, referral codes should be generated and display at the service level in the Support Plan e.g. Allied health and therapy - Podiatry. For any CHSP referrals, these codes will also be contained in a separate Referral Code Letter which is sent to the older person for ease of access. **Note:** if older person consents to electronic notifications, the Assessment Delegate can send these letters via email.	
Transition Care Program (TCP)	The hospital discharge staff will identify and liaise with a TCP provider to access these services using the referral code.	
Residential Care	For residential (including through MPSP), the assessor can issue a referral code following the assessment and delegate approval of services to enable the older person to take time to look for a suitable residential facility. Referral codes for residential care will be contained within the Support Plan attachment.	

9.4.8. Steps an assessor must take

An assessor must:

- Check availability of service providers in the older person's region. Commonwealth funded service provider contact details can be accessed in the My Aged Care Service Finder. Service providers will find the name of an older person's assessing outlet in the 'Plans' tab of the older person's record.
- If required (e.g. for vulnerable older people) contact providers on behalf of the older person when referring.

- Add additional documentation in the ‘Notes’ to ensure all pertinent information is available to service providers.
- Consider all referral options (through portal by broadcast, preference, direct referral, or issue referral code) and the service priority (excluding support at home).
- Consider referrals/recommendations to services not listed in My Aged Care.
- Where service availability is limited, work with the older person to explore alternative options of support to meet their areas of concern and goals.
- Discuss and record carer information and advise older people and/or their carers of carer support options available including requesting a call back for carers from a local Carer Gateway service provider or the National Dementia Helpline.

Assessors must ensure they are aware of appropriate care options within and outside Commonwealth funded aged care, such as local supports, health, community services and private services. To offer a broad range of strategies to assist the older person to achieve their goal, the assessor builds and maintains effective working relationships with service providers and extends connections with services and organisations in their local community, including those not listed in My Aged Care.

9.5. Corrections process

Assessment delegates are responsible for ensuring that all recorded decisions are accurate and complete. Diligent quality checks are essential to minimise the need for corrections and maintain accurate records.

Despite thorough quality checks, errors may occasionally occur. If an assessment delegate identifies an administrative or typographical error after submitting a decision, it is essential to initiate the correction process promptly.

When an error is identified, assessment delegates must submit a correction request within 42 days of the original decision. The correction request will be forwarded to the department for consideration.



See Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints for more information about the corrections process

10. Chapter 10: Support plan reviews and reassessments

What you'll find in this chapter:

This chapter provides guidance around the circumstances for conducting a support plan review (SPR) or a reassessment for each aged care program.

10.1. Reassessments under the *Aged Care Act 2024*

Section 64 of the *Aged Care Act 2024 (the Act)* provides for aged care needs reassessments. A reassessment may be required when an individual's circumstances have changed.

In the Act the term 'reassessment' is used as an umbrella term to describe both SPRs and reassessments. An individual may request a reassessment if they believe their aged care needs have changed, or it may be identified through a scheduled SPR.

> Note:
>
> In this manual, the term 'reassessment' is used to describe an assessment that occurs after an older person has already been assessed at least once.

SPRs are used as a mechanism to adjust an older person's aged care services without needing to undertake a reassessment. In some cases, the Assessment Delegate may approve access to services based on updated information through the SPR process. Seeking additional CHSP services alone would not generally warrant a new assessment.

A reassessment will be required when there are *significant* changes to a client's needs or circumstances.

Significant changes in care needs and circumstances require higher-level of care or different types of care (and/or changes to priority).

For example, an older person approved for ongoing Support at Home at the Classification 4 level who requires a higher classification level of package (e.g. Level 5) due to increased care needs or a change in priority for home care service must first undertake a reassessment by an assessor and approved by an Assessment Delegate.

Significant change is referenced in section 64 of the *Aged Care Act 2024* and defined in the *Aged Care Rules 2025*:

- a carer for the individual has permanently ceased to provide some or all care to the individual;
- the individual has experienced an event, or a decline in their condition, that is likely to mean that they will require:
    - more frequent access to a service they are already receiving, or
    - access to a service they have been approved for but are not currently receiving, or
    - access to new services not covered in the older person's access approval.

A triage delegate will determine whether an individual is eligible for a reassessment.

All reassessment requests begin through the SPR workflow in the assessor portal. A reassessment will be requested if required.

When a client undergoes a reassessment, the system will prompt assessors to review and update the client's urgency category, even if care needs have not changed.

For more information, refer to the user guide on how to conduct SPRs within the My Aged Care portal.

10.1.1. Support plan reviews (SPRs)

The introduction of Support at Home expanded the circumstances in which an SPR can be undertaken.

SPRs are most likely initiated by the older person's provider (with the older person's consent), who can submit a request through the My Aged Care service and support portal. When requesting SPRs, providers must attach supporting documentation about the participant's current care arrangements, such as their quarterly budget and/or care plan.

Alternatively, an older person or provider can ask for a SPR when:

- the older person's needs, goals or circumstances have changed,
- they need additional services that are not on their support plan, or
- a time limited service has ended.

An older person can request a SPR through My Aged Care, from a Services Australia Aged Care Specialist Officer or with assistance from a Care Finder or ECS worker. A SPR may lead to:

- no changes to the support plan as it meets the person's needs
- updates to the support plan to address changed needs; or
- a reassessment due to significant changes.

Where someone has made a request on behalf of the individual receiving the aged care service, it is important that the assessor confirms that the individual has consented to this occurring when beginning the SPR.

Team leaders are responsible for reviewing and prioritising SPRs, accepting an SPR and assigning it to an assessor. Urgent SPRs should be prioritised, particularly those for clients requiring access to the End-of-Life Pathway.

The assessor will review the information provided and determine whether the older person's updated needs can be addressed through a SPR or if a reassessment is required.

> Important: The current system functionality does not allow team leaders to identify Support Plan Reviews for the End-of-Life Pathway through the same mechanisms (team leaders will be able to filter by urgency, but they will be unable to see the visual indicator or filter specifically for End-of-Life). Instead, upon receiving urgent requests for Support Plan Reviews, it is important that team leaders click the double arrow icon to expand the referral card, verify whether it relates to the End-of-Life Pathway and prioritise it accordingly. This must be done for all incoming referrals for Support Plan Reviews to ensure older people seeking access to the End-of-Life Pathway are prioritised. A temporary workaround is available via Qlik, refer to the *Identification of End-of-Life clients Via Qlik – Guidance* on the *Assessment Hub* for more detailed guidance.

If the SPR is valid, any proposed changes to the Support Plan will require a decision by an Assessment Delegate. If a reassessment is required, the referral will proceed through the standard triage and assessment process, with new recommendations subject to delegate approval.

SPR records must contain information to support the decision made, including:

- whether contact was made with the older person and/or their supporter
- what information was obtained
- the outcome of the SPR assessment.

A key change which aims to reduce the need for SPRs is the flexibility of service recommendations in the IAT for any Support at Home classification. When an assessor accepts the Support at Home recommendation for a client, all services in the list will be pre-selected, with the exception of *Allied Health and Therapy* and *Therapeutic Services for Independent Living* service types. This is due to the specific nature of these services and should only be recommended if an older person has a need for those services.

10.1.2. Key principles of a support plan review

An assessor may set a review date on the support plan at the time of the assessment or initiate the review on an ad-hoc basis. Unplanned/ad hoc reviews may be requested by the service provider or through the contact centre or ACSOs.

- The SPR may be completed over the phone with the older person, their appointed decision maker, or in line with the older person's known will and preferences, their registered supporter. Note, Assessors are expected to contact the older person and/or their supporter as part of the SPR process. Where the SPR outcome is determined using referral information, assessors must clearly document the information and evidence relied upon to support the outcome.

- Assessors are best placed to make the decision as to whether an older person requires a reassessment following a review. This decision is supported by the information provided by the older person, the contact centre, service providers and health professionals.
- All SPRs are required to go through a delegate for approval.

- The My Aged Care contact centre has the ability to issue a direct referral to the assessment organisation for an urgent comprehensive assessment for residential care, residential respite care or transition care.
- If appropriate to the older person's aged care needs, a non-clinical assessor can create an assessment referral after starting the SPR.
- If an older person is admitted to hospital, it is best practice for an SPR to be conducted once the older person is discharged from hospital and there is a clear picture of the care needs and type and level of support that will be required.
- If an urgent referral is required before discharge, the SPR can be conducted in the hospital setting. This may mean that the referral needs to be transferred to an assessment organisation that is contracted to conduct assessments in a hospital setting (limited to State and Territory Governments). Alternatively, the assessor may contact the state or territory assessment organisation to self-refer directly.
- Where there is a significant change in an older person's needs or circumstances which affect the objectives or scope of the existing Support Plan, a reassessment may be undertaken.
- If the assessor has enough clear evidence to determine that a reassessment is required (due to a significant change in older person's circumstances), they can bypass the SPR process and refer direct to a new assessment by clicking the 'recommend new assessment' button in the 'before you start the Support Plan Review' window.

If not already scheduled earlier, a SPR may be routinely scheduled 12 months from the last assessment for older people with ongoing CHSP services in place. A reassessment is only required for significant changes in care needs or circumstances since the last assessment. The service provider is responsible for reviewing client services at least every 12 months.

- When conducting an assessment, assessors should be considering the current needs of the older person and not recommending services that aren't supported by the assessment.
- An unplanned SPR will replace the scheduled review in the system, and if necessary, can be re-scheduled at the completion of the unplanned review.
- An older person can have multiple reviews of their Support Plan linked to the same assessment.
- If new WHS information is recorded on the Support Plan following a SPR for an existing older person, the assessor should advise the provider of the new information so the provider can make the appropriate risk-based determination of how best to support the older person's service delivery.

Once a support plan review has been commenced, an assessor will be able to make changes to information in the following sections of the older person's Support Plan:

- Assessment summary
- Older person motivations
- Goals & recommendations, including recommendations for linking support & reablement.
- Manage services & referrals
- Associated People
- Review

It is important for the assessor to keep in mind that generated support plans can include goals and concerns from all previous assessments. The assessor should remove and/or update previous goals to ensure the focus remains on the older person's current goals and aspirations as per their most recent assessment and/or SPR.

Prioritising Urgent SPRs

While no priority category for SPRs exists as it does for assessment referrals (outlined in Chapter 4: Referral for assessment) assessors should prioritise SPRs where there is an identifiable urgent need. In particular, assessors should prioritise:

- **End-of-Life SPRs,** completing them as soon as possible. These will be marked 'urgent' in the system. Team Leaders can locate these in the Assessor Portal by filtering for urgency, then expanding the boxes to locate the EoL clients.
- Referrals where referral information indicates a significant event has occurred or the older person has a rapidly deteriorating condition, all of which will likely result in a reassessment. This will help ensure prompt review by a Triage Delegate.
- Requests for **a second unit of restorative care,** particularly those where there is a need for continuity of services

Otherwise, all other SPRs should be completed within calendar 15 days from the date the SPR referral is accepted.

10.1.3. Outcome of the SPR

After conducting the SPR, the assessor should consider possible outcomes, including: determining that no changes to the Support Plan are required (as it meets the older person's needs), updating the current plan, or conducting a reassessment.

The assessor can record the outcome to 'complete' the SPR and 'finalise' the SPR when it has been completed. If the SPR outcome is a reassessment, then the assessor is prompted to issue the assessment referral.

If the assessor assigns the referral to myself/my organisation, then they can start triage and should enter as much information as they can while conversing with the client at the end of the SPR. Note, a triage delegate must review the information entered by the assessor and complete the triage. The SPR referral will appear above the Assessment Summary Information in the older person's Support Plan.

> Note:
>
> A SPR should accurately reflect the review details, including date, attendees, mode, assessor name, reason for SPR and the outcome of the review (up to 1000 characters).
>
> Assessors must ensure the older person or active, appointed decision maker recognised under the Act (whether or not a registered supporter) agree to the details entered in the outcomes field as these comments will automatically appear on the older person's Support Plan.
>
> The Assessment Summary section of the Support Plan has a 5000-character limit which can also be updated with the SPR. All past versions of the Support Plan are retained on the My Aged Care system and are a record of any deleted content.

After selecting 'complete & finalise support plan review' no further changes can be made. Where applicable (e.g. if new services have been added or if a decision has been made to not approve a specific request), a Notice of Decision will be required to be prepared for Delegate approval and shared with the older person.

The assessor may determine that the older person's needs or circumstances have changed significantly since their original assessment, and a reassessment is required.

10.1.4. Reassessments

An older person may require a reassessment following a SPR in the following instances:

- the older person has multiple new needs or significantly increased needs
- the older person requires a different service group (i.e. client receiving CHSP needs to move to Support at Home) the My Aged Care assessor portal allows a reassessment referral where:
    - the SPR request meets one of the four defined scenarios only (transition care, residential care, residential respite care and older person relocation) or
    - if the request does not meet the defined scenarios and the SPR clearly needs to be converted to a reassessment, the assessor can issue a reassessment referral where they select 'A reassessment required' as the outcome of the SPR or
    - after the full SPR is completed and finalised, the assessor has the option to start a reassessment referral if this is appropriate.

Where the SPR outcome does not indicate a reassessment is necessary, but the person (or their active, appointed decision maker, whether or not a registered supporter) continues to request a reassessment, assessment organisations should be aware that making a decision not to proceed with a reassessment process is a reviewable decision under the Act.

If the triage delegate's clinical opinion (based on guidance materials and evidence) is that a comprehensive assessment is not required, the assessment organisation must ensure the older person:

- is aware of, understands and accepts this decision.
- is provided with the updated support plan which details the outcome of the SPR and if applicable, references the reason/s to the older person why the requested reassessment is not required at this stage; and
- is provided with information on how to request a further SPR should the older person's care needs or circumstances change.

If the older person does not accept the decision, then the assessment should proceed.

Reassessment of a classification level

Depending on the classification type for the service group, an individual or a registered provider acting on behalf of the individual may have the right to apply for a reassessment of a classification level under section 82 of the *Aged Care Act 2024.* Section 82 outlines who may apply for a classification reassessment for each classification type for a service group and when an application may be made. This is outlined in the table below.

Table 54. Circumstances when a classification reassessment can be sought

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
Ongoing or short-term for home support, assistive technology or home modifications	The individual	If: • the classification type is in effect for the individual; and • the individual considers a different classification level in the classification type for the service group should be approved; and • the funded aged care services are not being delivered under a specialist aged care program; and • it is considered the circumstances (if any) prescribed by the *Aged Care Rules 2025* (the Rules) apply.
Ongoing for residential care	The individual A registered provider on behalf of the individual	If: • The registered provider is delivering ongoing funded aged care services to the individual through the service group in an approved residential care home; and • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • the funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: • if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(2) of the Act in that time period; • it is considered the circumstances (if any) prescribed by the Rules apply.
Short-term for residential care	The individual The registered provider on behalf of the individual	If: • the applicant considers a different classification level in the classification type for the service group should be approved for the individual; and • an access approval is in effect for the individual for the classification type for the service group; and

Classification type for a service group	Who can apply for a classification reassessment	When can a classification reassessment be sought
		• if the application is made by the registered provider: • the registered provider is delivering short-term funded aged care services through the residential care service group to the individual in an approved residential care home; and • those funded aged care services are not being delivered under a specialist aged care program; and • either of the following apply: • if the rules prescribe a time period—not more than the number of applications prescribed by the rules have been made for the individual under subsection 82(3) of the Act in that time period; • it is considered the circumstances (if any) prescribed by the Rules apply.
Hospital transition (for any service group)	A registered provider on behalf of an individual	All of the following apply: the registered provider is delivering hospital transition funded aged care services to the individual through the service group; and • the registered provider or the individual considers that an extension of the period of effect for the classification level that is in effect for the individual for the classification type for the service group should be approved for the individual.

When a reassessment is needed (for all classifications expect those for the residential care service group), Triage Delegates will review the application, considering the individual's current care needs and whether they still meet the requirements for a classification reassessment.

If the application meets the necessary criteria, the assessor will complete a reassessment. The assessment delegate will decide whether to approve a different classification level for the classification type for a service group or an extension of the classification level (if relevant) under section 78 of the Act. All new decisions will be documented in a new Notice of Decision letter.

Note:

Individuals who are reassessed and approved for a higher classification level while awaiting funding in the Support at Home Priority System will have their position in the queue for their priority category based on their original approval date. If a new priority category is assigned, the individual's record in the system will be moved to that new priority category and their position in the queue is based on the original approval date.

10.1.5. Criteria for SPRs and reassessments by program

The table below describes the circumstances in which a SPR is required versus a reassessment.

Table 55. Circumstances when an SPR is required versus a reassessment

Program	Support plan review	Reassessment
Ongoing Support at Home 1-8	Approval for additional service types, or for additional services within the prescribed service types that have already been included in the support plan and is within the current SaH classification. This can be submitted by the older person's Support at Home provider.	An older person's circumstances have changed significantly that is likely to mean that they will require a higher classification level, with more frequent or a different type of funded aged care service. e.g. the individual's caring arrangements have ceased, permanently, to provide some or all care to the individual; or the individual has experienced an event, or a decline in their condition.
Restorative care	Approval for additional service types, or for additional services within the prescribed service types that have already been included in the support plan during the restorative care episode, or to provide evidence that a second unit of funding is required (may consider availability of units).	To meet changing needs of the older person which may include needing an ongoing service type after an episode of restorative care has finished (or during the period if circumstances change).
AT-HM	Changes to existing AT and/or HM funding tiers AT funding tier to access repairs or maintenance of an AT item listed on the AT-HM list. Addition of new AT and/or HM funding tiers for transitioned HCP recipients with insufficient HCP unspent funds (from November 2025).	Where there has been a significant change in needs which may include the individual requiring a higher ongoing Support at Home classification level or a different type of funded aged care service including a new need for AT and/or HM.

Program	Support plan review	Reassessment
End-of-Life Pathway	Request an urgent SPR to be assessed for End-of-Life Pathway if the person already has a Support at Home classification. Request an urgent SPR to move to an ongoing SaH. classification if the person needs services beyond the End-of-Life Pathway funding period.	A person who does not have a Support at Home classification will need a reassessment to be approved for the End-of-Life Pathway.
Residential care- (permanent)	N/A	Clients needing residential care who have not had residential care added as a care type to their support plan.
Residential care- (respite)	N/A	Clients needing residential care who have not had residential care added as a care type to their support plan.
TCP	N/A	If the client receiving other aged care services enters hospital and needs TCP, a reassessment is required.
CHSP	To meet changing needs which may require additional CHSP services. To close off a period of reablement support and/or meet changing needs which may include needing an ongoing service type after episode of reablement has finished.	If a CHSP participant needs access to a different service type that they are not currently approved for. For example, Support at Home or residential respite care, a reassessment is required.
MPSP	If a client is receiving other aged care services and an MPSP service recommendation needs to be added.	New MPSP clients will require an assessment from 1 November 2025. If an existing MPSP client who had not previously been assessed (who were deemed across under transitional arrangements) needs to move to mainstream services, a reassessment should be undertaken.
NATSIFACP	If a client is receiving other services and a NATSIFACP service recommendation needs to be added.	New NATSIFACP clients will require an assessment from 1 November 2025. If an existing NATSIFACP client needs to move to mainstream services and

Program	Support plan review	Reassessment
		hasn't been assessed before, a reassessment should be undertaken.

10.1.6. SPRs for Aboriginal and Torres Strait Islander assessment organisations

SPRs will usually be reallocated to the assessment organisation that completed the previous assessment. As Aboriginal and Torres Strait Islander assessment organisations commence, an Aboriginal and Torres Strait Islander client may wish to transfer their SPR to one of these organisations. In such case, the current assessment organisation is expected to support a warm transfer of the assessment referral. This approach ensures continuity of care, respects client choice, and supports culturally safe aged care assessment delivery.

10.1.7. SPRs for AT-HM

Participants accessing assistive technology (AT) or home modifications (HM) through Support at Home can request a SPR:

- to seek an increase in AT or HM funding tier
- to seek AT funding to meet their assistive technology repair or maintenance needs
- to seek allocation of an AT or HM funding tier if they are a participant with a transitional AT-HM classification (from November 2025).
- to seek an AT or HM funding tier for the Restorative Care Pathway noting AT-medium and HM-medium gets auto-recommended when recommending End-of-Life)
- to seek an AT funding tier for End-of-Life Pathway (noting AT-medium gets auto-recommended when recommending End-of-Life)
- to seek AT ongoing Assistance Dogs funding
- to seek AT-HM funding tiers for older people with progressive conditions (as listed for AT-HM scheme)

The following will require a reassessment:

- Older people with only a SaH ongoing classification (e.g., not accessing the Restorative Care Pathway or End-of-Life Pathway) who do not have approval for AT-HM (either transitional tiers or low-high tiers), and where funding cannot be given through an SPR.

Note: Assessment and funding allocation timelines should be considered when providers are planning service delivery and advising participants to ensure there is no service gap.

If an SPR is requested for a higher AT or HM funding tier or for repair and maintenance of assistive technology, providers will be required to submit evidence, along with the SPR request, for the aged care assessor to review evidence.

Evidence may include one or more of the following:

- information provided by a registered health practitioner or allied health professional working within their professional scope of practice (prescription, report or letter)
- information provided by a registered provider delivering SaH/Restorative Care/End-of Life Care (care notes, AT-HM quote, evidence of price, statutory declaration)

Where SPRs are requested to increase funding needs:

- the original funding tier entry date applies
- the amount available in the funding account will be minus any already spent funds from the originally approved tier
- the same tier may not be approved again – noting that this would not represent an increase in funding. For example, an older person with an AT medium should not be approved for another AT medium tier through SPR. If their needs have increased, they could instead be approved for an AT high tier if required.

10.1.8. SPRs for Restorative Care Pathway (RCP)

Restorative care partners can submit a SPR for several reasons related to the RCP including:

- Request approval for additional services which were not approved at assessment but are required to meet goals identified in the Goal Plan
- Request approval for additional unit of RCP funding to be accessed concurrently
- Request a reassessment due to changing needs

Like other classifications, a provider can submit a SPR requesting additional services to ensure goals can be met.

Second unit of funding for Restorative Care Pathway

Under paragraph 195(3) of the Act, a provider may submit a SPR to request a second concurrent unit of Restorative Care Pathway (RCP) funding for a person already approved for, and accessing, the RCP. To approve the SPR, an assessment delegate must confirm that the person is entered into services and consider the evidence provided outlines sufficient justification of higher needs for multidisciplinary allied health and/nursing services to achieve identified restorative care goals. Assessment delegates may also consider the availability of RCP funding units for allocation.

Where an initial RCP place has been withdrawn due to the person not entering care within the required take up period (56 days, with a possible 28-day extension), a second unit must not be approved via an SPR. In these circumstances, an SPR should not be used to attempt to approve a second unit RCP but may be used to assess and approve alternative supports (including the need for a reassessment), based on the person's needs. Access to a second unit of funding is requested through a SPR. A clinical assessment delegate will need to consider written evidence provided to determine approval (refer to Chapter 6 for information on manual oversight of RCP units/places). Evidence includes written confirmation from a medical practitioner, registered nurse or allied health practitioner, or restorative care partner of the registered provider that the individual requires additional funding to access nursing care and allied health and therapy services to achieve restorative care outcomes as detailed in the goal plan. Further supporting evidence can include the goal plan, clinical assessment tool outcomes, and individualised budget. Where an older person is already receiving

ongoing services, information should be provided to demonstrate adjustments to ongoing services is also not sufficient to achieve restorative outcomes in combination with their initial RCP unit of funding. Availability of RCP units may also be considered.

> Important:
>
> There are certain number of places available during the financial quarter for RCP units. Assessors and delegates should monitor departmental communications regarding RCP unit availability, particularly where a second unit is being considered. Requests for second RCP unit contribute to the overall management of available RCP units and should only be made where clinically appropriate and supported by evidence,



For more information on the Restorative Care Pathway please refer to the Support at Home Manual.

Recommending ongoing services after/during a period of Restorative Care Pathway

Assessors should consider any potential needs after exiting from the RCP, it may be necessary to undertake a reassessment for ongoing funding towards the end of the RCP episode.

The intention of RCP is to improve levels of function and delay the need for ongoing or higher levels of ongoing aged care services. This can only be determined after the RCP episode has been completed. The restorative care partner could request a reassessment if it is anticipated ongoing services may be required or there has been a change in circumstances.

10.1.9. SPRs for the End-of-Life Pathway

SPRs are used in the context of the End-of-Life Pathway for the following reasons:

- For existing Support at Home participants, to move from their current ongoing Support at Home classification to the End-of-Life Pathway
- For participants accessing the End-of-Life Pathway who require services beyond the End-of-Life funding period, to move from the End-of-Life Pathway to an ongoing Support at Home classification

In both cases above, the SPR should be marked as an ‘urgent’ SPR.

Funding under the End-of-Life Pathway can be used for a maximum of 16 weeks. An urgent SPR can be requested any time after 12 weeks if it appears the participant will require services that exceed the End-of-Life funding period. The SPR will enable the participant to:

- Return to their previous ongoing Support at Home classification, if they were already receiving services under Support at Home, or
- Transfer to the ongoing classification that was determined at assessment, in the case of participants who were new to Support at Home when they commenced the End-of-Life Pathway.

It is critical that SPRs to transfer a participant from the End-of-Life Pathway to ongoing services are prioritised in order to ensure there is no break in continuity of service. If a

participant is returning to an ongoing Support at Home classification that is considered insufficient for their needs, a reassessment may be needed. However, the SPR to return the participant to their current ongoing classification should be completed first, in order to ensure funding is made available. After this, a reassessment can be requested.

Where the participant was new or was an existing Support at Home participant prior to accessing the End-of-Life pathway (e.g., was not previously accessing CHSP), when completing the SPR, the assessor must ensure they transfer the participant to ongoing services through the SPR process instead of referring to a new assessment from the SPR process. End-of-Life participants should only be referred for a new assessment through an SPR where they were accessing another program prior to accessing the End-of-Life pathway (such as CHSP).



Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 3 – Managing Referrals for Assessment and Support Plan Reviews

11. Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints

What you'll find in this chapter:

This chapter provides information on assessment related reviewable decisions in accordance with the *Aged Care Act 2024 (the Act)*. It also details:

- the reviews process
- the corrections process
- options for reviews and revocations
- the pathways that clients can take to submit complaints and raise concerns about their My Aged Care experience.

The primary audience for this section is assessors, team leaders, delegates and operational managers. Assessors should be aware that they are providing a valuable and trusted public role in the delivery of quality aged care assessment services on behalf of the Commonwealth. A necessary part of a quality assessment is having supporting processes that allow the older person the right to complain without fear of reprisal, while also upholding the statement of rights and principles.

11.1. Reviewable decisions

The Act broadens the scope of reviewable decisions related to the assessment process. It is essential for all delegates to be aware that certain decisions can be reviewed, and to ensure that every decision made is thoroughly documented and supported by evidence.

Section 557 of the Act outlines the decisions made by the System Governor that are subject to review, including those related to assessments and assessment-related activities. This section also identifies the specific entities affected by each reviewable decision.

An affected entity for a reviewable decision is a party that has the right to seek a review of a decision. To find out whether a person is an affected entity in relation to a reviewable decision refer to column 2 of section 557 of the Act.

An older person's registered supporter/s can communicate the decision of an older person to seek a review of a decision. It is not the role of a registered supporter to make decisions for an older person. If an older person has an active, appointed decision maker recognised under the Act, that person may make a decision on behalf of an older person to seek a review of a decision. They may only do this if this decision is within the scope of their legal authority and that legal authority is active.

11.1.1. Reviewable decisions related to assessment

Table 56 is an excerpt of the table in Section 557 of the Act relating to decisions made by the System Governor that relate to assessment.

Table 56: Reviewable decisions made by the System Governor that relate to assessment

Item	Decision	Simplified explanation	Entity
7	A decision under subsection 57(1) not to make an eligibility determination for an aged care needs assessment for an individual	Deciding that an individual is not eligible for an aged care needs assessment	The individual (the older person)
8	A decision under subsection 64(1) that a reassessment of an individual's need for funded aged care services is not required	No need for reassessment: Deciding that an older person does not need a support plan review or reassessment of their aged care needs	The individual (the older person)
9	A decision under subsection 65(1) that an individual does not require access to funded aged care services	No need for aged care services: Deciding that an older person does not need funded aged care services	The individual (the older person)
10	A decision under subsection 65(2) not to approve a service group, or a classification type for a service group, a service type, or a funded aged care service, for an individual	Not approving certain services: Deciding not to approve a service group, service types or services, or classification types for an older person	The individual (the older person)
11	A decision under subsection 65(4) that exceptional	No exceptional circumstances: Deciding not to	Each of the following:

Item	Decision	Simplified explanation	Entity
	circumstances do not apply in relation to an individual	approve access where an older person has not undergone a needs assessment.	(a) the individual (the older person); (b) the registered provider
12	A decision under subsection 71(2) to not specify an earlier day in a notice of decision under section 70	Not setting an earlier date: Deciding not to backdate the date of approval in the notice of decision for an older person.	The individual
13	A decision under subsection 71(6) to reject an application for a longer period for an individual to make an application	Rejecting a longer application period: Deciding not to give an older person more time to submit an application to have their date of approval backdated	The individual (the older person)
14	A decision under subsection 74(1) to revoke an eligibility determination for an aged care needs assessment for an individual	Revoking eligibility for an assessment: deciding to cancel an older person's eligibility for an assessment	The individual
15	A decision under subsection 74(1) to revoke an access approval for an individual	Revoking eligibility for aged care: Deciding to cancel an older person's eligibility for aged care services	The individual (the older person)
16	A decision under subsection 78(1) to establish a classification level for an individual for	Setting a classification level: Deciding on a classification level for an older person for a specific	Each of the following: (a) the individual; (b) if a copy of the notice of the

Item	Decision	Simplified explanation	Entity
	a classification type for a service group	classification type in a service group	decision is required to be given to a registered provider under subsection 79(3)—the registered provider
17	A decision under subsection 83(1) to change a classification decision (the original decision) for an individual	Changing a classification decision: Deciding to change a previous classification decision for an older person	Each affected entity for the original decision
18	A decision under subsection 86(1) to assign a priority category for a classification type for a service group	Assigning a priority category: Deciding on a priority level for an older person for a specific service group	The individual
19	A decision under subsection 90(1) to change a decision about an individual's priority category for a classification type for a service group	Changing a priority category: Deciding to change an older person's priority level for a specific classification type for a service group	The individual (the older person)

11.2. Reconsiderations process

If an affected entity is not satisfied with a decision that is reviewable under the *Aged Care Act 2024* (the Act), they are encouraged to first contact their assessment organisation to discuss their concerns in the first instance. The affected party may also submit a written **reconsideration request within 28 days** of receiving the decision notice:

By Email:

agedcarereviews@health.gov.au

By Post:

The System Governor
Department of Health, Disability and Ageing
Attn: Review of Decisions Section
GPO Box 9848
ADELAIDE SA 5001

Visit for more information: Request for an Internal Review of a Decision Form | My Aged Care

This request must set out reasons why they are seeking a review. The System Governor can allow further time for someone to make a request for reconsideration (see subsection 559(3)(c) of the Act.)

The reconsideration will be conducted by an internal decision reviewer who is different from the original decision-maker, holds equal or higher position and was not involved in the making of the original decision.

The internal decision reviewer will be a departmental delegate of the System Governor and will carry out a comprehensive administrative review of the original assessment organisation's decision.

They will consider all relevant information, including new evidence from third parties before making a determination. They must also, within 14 days of receiving the request, provide the affected entity written notice that the request has been received and when it was received. The notice must also set out that if the internal reviewer has not provided notice of their decision within 90 days of receiving a request, the original decision has been affirmed.

The internal decision reviewer must make a decision within **90 days** after receiving the request. They may:

- Affirm the original reviewable decision.
- Vary the original reviewable decision.
- Set the reviewable decision aside and make a new decision.

After making their decision, the internal decision reviewer must give written notice of the following to each affected entity for the reviewable decision:

- the reconsideration decision;
- the day the reconsideration decision was made;
- the reasons for the reconsideration decision;

- details of the affected entity's right to apply to the Administrative Review Tribunal for review of the reconsideration decision.

If the affected entity is still not satisfied after the review, they may apply for a further review by the Administrative Review Tribunal.

11.2.1. The role of assessors in reconsiderations

During the reconsideration process, the Departmental delegate may discuss the request with the assessor through the assessment organisation's Operational Manager. This step helps clarify any matters related to the case.

Assessment organisations play a vital role in the reconsideration process. They may be invited to provide additional information in response to the request for review, including the rationale for their decision making. Any additional information will be carefully considered as part of the administrative review.

11.2.2. New point in time assessment

If the Internal Review Officer identifies that there has been a significant change in the older person's circumstances since the original decision, they may discuss with the older person, the option of pursing a reassessment and withdrawing their review request.

If the older person decides to withdraw their review request, the Department will facilitate the reassessment and cease to deal with the matter.

> Important:
>
> The Department cannot discontinue the review process unless the older person chooses to withdraw their application.

If the older person decides to pursue a new point-in-time reassessment, the Internal Review Officer will instruct the assessor to conduct a reassessment.

11.2.3. Supplementary off-line assessment by assessment organisation to inform the reconsideration process

When a review officer determines that a supplementary off-line assessment is required to support a review decision, they may request that it be undertaken. This scenario typically arises when it appears that an incorrect decision may have been made, but the Internal Review Officer requires updated information to determine the most appropriate assessment outcome. The outcome of this assessment will contribute to the body of evidence considered as part of the review process. This process is distinct from a reassessment because a reassessment stems from a change in circumstances. In the case of a reassessment, the outcome would not be backdated to the time of the original assessment.

Requests for off-line supplementary assessments are infrequent and are only made when necessary to support a thorough and fair reconsideration process.

Through the assessment organisation's operational manager, the Internal Review Officer will request the off-line supplementary assessment in writing. It will be necessary to use the paper-based version of the Integrated Assessment Tool (accessible from the My Aged Care assessor portal) or other form as specified by the Internal Review Officer.

The off-line supplementary assessment is usually performed by an assessor who was not involved in the original decision or by a different assessor from the same organisation. To ensure a comprehensive evaluation, the reassessing assessor can collaborate with the original assessors, the original Assessment Delegate, and any other relevant parties as needed.

The assessor must not discuss the supplementary off-line assessment outcome with the older person or any other party in any way after completing the assessment. The outcome of the supplementary off-line assessment is not recorded in My Aged Care by the assessment organisation. Instead, it is shared with the Department through the assessment organisation's operational manager.

11.2.4 Role of Internal Decision Reviewer in relation to Support at Home Reviewable Decisions

Where an older person (or their appointed decision maker), is unhappy with a Support at Home classification or priority decision, they can submit a written request to the Department for the decision to be reconsidered. The older person can be assisted by their supporter to submit the request. The role of the Internal Decision Reviewer is to, standing in the shoes of the original decision maker, consider whether the correct decision has been made in accordance with the relevant legislation and on the basis of the information and evidence provided. The Departmental Delegates conducting the internal review of Assessment Decisions are subject to the same legislative limitations as the original decision maker.

Where a request to reconsider a classification decision is received by the Department, the Internal Decision Reviewer will consider whether any of the inputs into the IAT are incorrect or need amendment, having regard to all the evidence available to the original decision maker. The Internal Decision Reviewer may also request further information or documents necessary to reconsider the decision. If this process results in the older person receiving a different Support at Home Classification level, then the original decision will be set aside and substituted with the new decision. This process ensures the integrity of the classification algorithm and ensures that program funding is allocated consistently and equitably to all participants based on their needs, in accordance with the criteria described in the Rules.

Similarly, where a request to reconsider the decision to assign a priority category is received by the Department, the Internal Decision Reviewer will consider the evidence relied on by the original decision maker to determine whether the criteria set out in the Rules was appropriately applied. The Internal Decision Maker may also request further information or documents necessary to reconsider the decision. If, on review of the evidence and information before the internal reviewer, it is determined the individual is eligible for a different priority category, the original decision will be set aside and substitute the decision with a new priority category.

As part of the internal review process, the Internal Decision Reviewer will seek additional evidence from the Applicant, and other third parties including the AO, any home care provider or medical practitioners.

11.3. Further avenues of review

If affected entities remain dissatisfied with the outcome of the review, they can apply to have their reconsideration decision reviewed by the Administrative Review Tribunal (ART).

If an affected entity has concerns about the way a decision was made or the processes involved, they can make a complaint to the Commonwealth Ombudsman.

11.3.1. Administrative Review Tribunal (ART)

If a person who has requested a reconsideration of a decision is not satisfied with the outcome, they may apply to the ART for a further review. It is important to note that there is a cost to the applicant for initiating this process.

Assessment Delegates must ensure that all information used in making approval decisions, including any data gathered during reviews of reviewable decisions is properly maintained and readily available for review by the ART.

Both the Assessment Delegate who made the original decision and the Department delegate who made the review decision may be required to appear before the ART as part of the review process.

11.3.2. Commonwealth Ombudsman

The Commonwealth Ombudsman is responsible for considering the administrative actions and decisions made by Australian Government agencies. The Commonwealth Ombudsman will not make a fresh decision on the matter, rather they will consider the way a decision was made and make recommendations on how the decision or process could be improved.

The Ombudsman's office handles complaints, conducts investigations, performs audits and inspections and carries out specialist oversight tasks to determine whether the actions and decisions of agencies are wrong, unjust, unlawful, discriminatory or unfair.

An older person, or any person supporting them such as their carer, advocate or registered supporter, can contact the Commonwealth Ombudsman through the official website to raise their concerns or file complaints.

11.4. Revocations

Triage and Assessment Delegates are not delegated the power to consider or decide to revoke an older person's eligibility or approval decisions. These delegated powers are exercised by department delegates (delegates employed directly by the department).

11.4.1. Revocations on the initiative of the System Governor

There are specific circumstances where an approval or eligibility decision may be revoked. One scenario is that during the assessment or application process the individual gave information or documents and those information or documents were false or misleading, omitted any matter or thing that without would make the document false or misleading. This can include situations where key facts presented during the assessment process were inaccurate or misleading, resulting in the approval or eligibility decision being granted erroneously. In such cases, it is the departmental delegate's responsibility to assess the evidence and, if warranted, initiate the revocation process to maintain the integrity of the aged care system.

Decisions to revoke an eligibility determination for an aged care needs assessment and access approval for an individual are reviewable decisions under Section 557 of the *Aged Care Act 2024.*

If an assessor or assessment delegate has concerns about the information or documents provided by an older person and/or their registered supporter(s) or appointed decision makers, they should contact the Department at AssessmentRevocations@health.gov.au

Before making a final decision to revoke eligibility or access approval, the Departmental delegate must follow the structured process outlined under the Act. The Departmental delegate must first notify the individual in writing that a decision to make a revocation is being considered. The notice must clearly state the reasons why a revocation is being considered and invite the individual to make written submissions about the matter within 14 days of receiving the letter (or a longer period if specified). Additionally, the notice must inform the individual that the Departmental delegate may proceed with the decision after considering the submissions.

If an individual has made their submission, the Departmental delegate is required to carefully consider them before making a final decision. This ensures that the individual's perspective and any relevant information are taken into account, allowing for a transparent and fair assessment of the situation.

If, after considering the submission, the Departmental delegate deicides to revoke the eligibility determination or access approval, they must notify the individual in writing within 14 days of making the decision. The notification must include the decision itself, the reasons for the decision, and information on how to apply for a reconsideration if the individual wishes to challenge the outcome.

If an eligibility or access approval is revoked, any pending applications related to the individual are automatically withdrawn. This means the individual will need to reapply for access if they wish to receive funded aged care services.

11.4.2. Requests on the initiative of the individual

Approvals can be revoked if the individual themselves requests it. Under section 72 of the Act, an individual has the right to request the revocation of an eligibility determination or an access approval if it is currently in effect. This option to withdraw an eligibility approval is only available if the individual is under the age of 65 at the time of making the request. The request for revocation must be submitted using the approved form to ensure that the process is formally documented and consistent with legislative requirements. Once a valid request for revocation has been made, the System Governor is obligated under section 73 to revoke the eligibility determination or access approval within 28 days of receiving the request. The decision must be communicated to the individual within 14 days of being made in the form of a written notice. This notice should clearly outline the revocation decision, including any relevant reasons and implications.

> Note:
>
> Once an approval or eligibility determination is revoked, any pending applications related to that individual under section 56 or 64 are automatically considered withdrawn.
>
> This means that no further action will be taken on those applications.

Additionally, approvals lapse automatically if they are superseded by a subsequent decision. This occurs when a new eligibility determination or access approval replaces the existing one, rendering the previous approval invalid. In these cases, the revocation happens implicitly because the new decision takes precedence.

11.5. Corrections process

Assessment delegates are responsible for ensuring their decisions are recorded accurately and completely. Diligent quality checks are essential to minimise the need for corrections and maintaining accurate records.

If an administrative or typographical error is identified after submitting a decision, assessment delegates must promptly initiate the corrections process. As an example, errors could include an omission of funded care types from an individual's approval that were recommended in the Support Plan and the delegate intended to approve; or entering an incorrect approval date of effect (delegation date) that does not match the actual approval date of effect.

Where an error has been identified, an assessment delegate must request a 'correction' **within 42 days of the original decision**. Corrections should be requested via the 'Decision History' tab in the My Aged Care Assessor Portal using the 'Request Changes to care approval decisions' button. Additional information that does not fit in the free text field should be forwarded to the department for consideration, via email at the following address: reviewable.decisions@health.gov.au

The reason for the correction must be recorded when lodging the request. For example, "*Ongoing residential care omitted from online approval process, evidence of an ongoing residential care recommendation in Support Plan*." For the department to agree to the correction, the assessment delegate's intention (as at the time the decision was made) should be clearly evident though assessment documentation and/or other supporting documents on My Aged Care.

If the assessment information is not consistent with the correction request, the department will reject the request. In instances where a client's needs change after the original decision, a reassessment should be undertaken.

In situations where the Assessment Delegate has reconsidered their decision and changed their mind after recording the approval (based on additional information they have received), a correction request is not appropriate, and a reassessment is required. Any correction requests received by the department for this reason will be rejected.

A correction cannot be requested where service referrals have been issued for services. Where a correction is required for an assessment and service referrals have been issued, the assessment organisation must recall all services in an 'issued' state before they can request a correction.

If it is identified a correction is required after a service referral has been accepted or services have commenced, the correction should be escalated to the department via email at the following address: reviewable.decisions@health.gov.au

11.6. Complaints

Older people (and/or their carer/advocate/registered supporters) have the right to raise their concerns about the information, service or care they have received from My Aged Care, their assessor or service provider.

There are different ways to make a complaint depending on the part of My Aged Care that the concern relates to, such as:

- the My Aged Care Contact Centre
- aged care assessment with an assessor
- the outcome of an aged care assessment
- the care and services received from a service provider; or
- the conduct of a registered supporter.

11.6.1. Concerns about My Aged Care

An older person or registered supporter should discuss their concerns about the service or information they receive from My Aged Care with the contact centre in the first instance.

If they are unable to resolve the issue, My Aged Care will provide a reference number to track the progress of the complaint. A person can make a complaint by:

Calling My Aged Care on 1800 200 422.

Posting their complaint to:

My Aged Care Complaints
PO Box 1237
Runaway Bay QLD 4216

An assessor can make a complaint or escalate an issue about contact centre services by calling the My Aged Care Service Provider and Assessor Helpline on 1800 836 799.

If an older person, assessor or provider is not satisfied with the response received, they can take further action by sending an email with the detail of their complaint, and their My Aged Care reference number to: myagedcaresupport@health.gov.au

11.6.2. Concerns about the assessment

Assessment organisations are required to have a complaints procedure in place.

If a person has concerns about their assessment, they are advised to contact the assessor or their assessment organisation in the first instance.

If the department receives a complaint through My Aged Care, it will be referred to the relevant assessment organisation for investigation and/or resolution. The assessment organisation will report back to the department on the outcome.

If the person cannot first resolve the issue with their assessor or their organisation, they are advised to call My Aged Care for assistance on 1800 200 422. Complaints relating to assessment organisations are escalated to the department for investigation.



My Aged Care Complaints

My Aged Care Quality in Aged Care

11.6.3. Complaints about an aged care provider

If an older person (and/or their carer/advocate/registered supporter/appointed decision maker) is unhappy with any aspect of the care or services being received through an aged care provider, they can:

- Speak to their service provider about their concerns
- make a complaint to the Aged Care Quality and Safety Commission (ACQSC):
    - By calling 1800 951 822
    - By completing an online form on the commission's website
    - In writing to:

        Aged Care Quality and Safety Commission
        GPO Box 9819, in your capital city

An assessor can also make a complaint with the ACQSC if they have concerns about an aged care provider.

In addition to the above, complaints about care received from Multi-Purpose Service Program (MPSP) providers or Transition Care Program providers can be referred to the relevant state and territory health department complaints bodies.

MPSP providers also have an obligation, under their MPSP agreement with the Commonwealth, to ensure their respective state or territory is advised when complaints have been made by an individual about the aged care or health services being delivered.



ACQSC: Aged Care Service Provider Complaints

ACQSC: Lodge a Complaint

11.6.4. Complaints and concerns about registered supporters

Any person or organisation can raise a complaint or concern with the System Governor relating to a registered supporter's conduct, including alleged non-compliance with the duties of a registered supporter. The System Governor can suspend and/or cancel the registration of a supporter. This may occur at the request of an older person or registered supporter, or at the initiative of the System Governor.

Complaints or concerns can be raised by anyone. This includes an older person, their other registered supporters, appointed decision makers, aged care providers or workers, medical or allied health practitioners, advocates or any other person who is concerned for the welfare or treatment of themselves or the older person.

Assessors have a role in raising or handling complaints, concerns, or requests to cancel the registration of a supporter by escalating any relevant information to the departmental delegate responsible for supporters. This includes any request from an older person or their registered supporter to cancel the relationship where the circumstances mean the registered supporter may be suspended under the *Aged Care Act 2024* (the Act), or any other complaint or information that suggests a registered supporter is not complying with their duties under the Act. This includes anything an assessor notices at an assessment.

Concerns and complaints can be raised using the online form for making a submission to the System Governor responsible for supporters.

Information about the duties of a registered supporter and the complaints process can be found in the policy library for registered supporters.

Complaints about aged care providers, including their engagement with registered supporters, can be made to the Aged Care Quality and Safety Commission.

11.6.5. Complaints about aged care policies

Complaints related to Australian Government aged care policies, guidelines or decisions should be referred to the Department of Health, Disability and Ageing.

12. Chapter 12: Supporting diverse experiences and needs

What you'll find in this chapter:

This chapter outlines the ways in which the aged care system supports an older person's diverse needs by ensuring they have access to person-centred aged care assessments and services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences.

12.1. Supporting diverse needs during an assessment

The Department of Health, Disability and Ageing, Australian Government agencies, aged care assessment organisations, providers and the aged care workforce must ensure that older people have access to person-centred, culturally safe, trauma aware and healing informed aged care assessments and services. This includes valuing older people, their identities, cultures, abilities, diversity, beliefs and life experiences.

The Aged Care Diversity Framework provides guidance for an accessible aged care system for every older person.

The Statement of Principles in section 25 of the *Aged Care Act 2024* (the Act) provides for an aged care system that offers accessible, culturally safe, culturally appropriate, trauma-aware and healing-informed aged care services, based on the needs of the individual, regardless of their location, background and life experiences. This may include individuals who:

- are Aboriginal or Torres Strait Islander persons, including those from stolen generations
- are veterans or war widows
- are from culturally, ethnically and linguistically diverse backgrounds
- are financially or socially disadvantaged
- are experiencing homelessness or at risk of experiencing homelessness
- are parents and children who are separated by forced adoption or removal
- are adult survivors of institutional child sexual abuse
- are care-leavers, including Forgotten Australians and former child migrants placed in out of home care
- are lesbian, gay, bisexual, trans/transgender or intersex or other sexual orientations or are gender diverse or bodily diverse
- are an individual with disability or mental ill-health
- are neurodivergent
- are deaf, deafblind, vision impaired or hard of hearing
- live in rural, remote or very remote areas.

It is important to understand that individuals may identify across more than one group and may have a variety of special and diverse needs that will need to be recognised and taken into consideration.

During the assessment process, assessors must consider how they can create a safe assessment setting and ensure older people have a trusted support person present if needed. This may be a carer, partner, registered supporter, friend or perhaps a member from their 'family of choice' (who may or may not include biological family). This will help to build trust and ensure that an assessor can collect all information necessary to develop an appropriate and tailored Support Plan with the older person that considers their diverse needs.

It is important to recognise that many older people with diverse needs, characteristics and life experiences may have experienced exclusion, discrimination and stigma during their lives and may not feel safe to reveal such potentially sensitive information in an assessment.



Aged Care Diversity Framework

12.2. Understanding cultural safety for older Aboriginal and Torres Strait Islander people

The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council's (NATSIAACC) definition of cultural safety (referenced below) was co-designed in 2024 and included in the revised explanatory memorandum accompanying the Aged Care Bill 2024.

All workers in the aged care system, including assessment staff, are expected to critically self-reflect and take responsibility for building an understanding of how they can improve their approach to culturally safe care in their daily practice.

Assessors are required to complete an introduction to cultural safety as part of the induction training through MAClearning to ensure they understand why cultural safety is important in providing safe aged care experiences for older Aboriginal and Torres Strait Islander people. It is also required that assessment organisations provide their staff with additional cultural safety and trauma aware, healing informed training relevant to the customs and protocols local to the area in which they operate.

Further to this, it is recommended that assessment staff undertake additional training on how to understand and support the Stolen Generations. As of 2022, all Stolen Generations survivors are aged 50 or over and therefore may be eligible to receive aged care services. Many Stolen Generations survivors live in urban and regional locations where there are few, if any Aboriginal and Torres Strait Islander community controlled aged care services and facilities.

When assessing Aboriginal and Torres Strait Islander clients, it is important to be guided by the individual's preferences and observe body language and respond respectfully. If appropriate, assessors are encouraged to tailor their assessment approach to the specific needs of individuals to ensure that their support requirements are accurately reflected in their support plans. This may include:

- using a trusted cultural broker, or advocate, or including contact with an Elder Care Support worker where available
- using supplementary assessment components of the IAT that are best suited for assessing the older person's needs. This may include the use of the Kimberley Indigenous Cognitive Assessment (KICA) assessment tools and the Good Spirit,

Good Life guide in the Integrated Assessment Tool (IAT) for older Aboriginal and Torres Strait Islander people. These have been validated as the most acceptable and reliable instruments for assessing the needs of Aboriginal and Torres Strait Islander people, and/or

- developing relationships that support regular interactions and mentorship with existing and trusted health services and specialist providers located within a local community,
- working with existing Aboriginal Community Controlled Organisations (ACCOs) Aboriginal Community Controlled Health Organisations (ACCHOs) affiliates and other First Nations organisations who specialise in providing aged care services where they are available.



Aboriginal and Torres Strait Islander aged care | Australian Government Department of Health, Disability and Ageing

The KICA and the Good Spirit, Good Life guides are in the IAT User Guide

NATSIAAC definition of cultural safety

'Cultural safety requires understanding of one's own culture and the impact that your culture, thinking, and actions may have on the culture and wellbeing of others through ongoing critical self-reflection.

Only the care recipient themselves can determine whether the service is culturally safe. Ensuring access to a culturally safe, respectful, responsive and racism free aged care system is inherent for the optimal safety, autonomy, dignity, and absolute wellbeing of Aboriginal and Torres Strait Islander Elders, senior and older people, their families and community.

Aged care service providers and workers must take responsibility for building trust and relationships with Aboriginal and Torres Strait Islander service users, and their families, and for creating a new aged care system which centres on their living experience, cultural, and ageing needs, as determined by Aboriginal and Torres Strait Islander service users themselves.

The implementation of a trauma aware, healing informed approach to professional practice, and facilitating a greater understanding and respect for individual and collective cultures, histories, knowledges, traditions, stories, and values of Aboriginal and Torres Strait Islander service users, their families and communities, will greatly support the delivery of a quality and culturally safe aged care system.

Aged care service providers must also firmly commit to continuously measure and improve structures and behaviours necessary for cultural safety and quality support to remain embedded in the Australian aged care system.'

12.3. Cultural safety for other cohorts

Cultural safety is an important consideration for all culturally distinct groups, for example culturally and linguistically diverse and lesbian, gay, bisexual, trans/transgender, intersex+ communities. It's important for assessors to recognise and respect the identities and customs of all older people who are culturally different from themselves, and have different life experiences, to provide equitable outcomes and quality assessment services.

Respecting a person's identity, culture and diversity in aged care should focus around understanding their individual needs and preferences and providing an assessment that is reflective of and responsive to their social, cultural, linguistic, religious, spiritual, psychological, medical and other needs, including cultural safety.

Assessments for all older people, regardless of culture or background, should be conducted in a way that is:

- **Welcoming and open-minded:** an assessor truly listens to the older person and works from the older person's cultural perspective, rather than their own
- **Respectful:** recognises their cultural identities and customs and does not challenge, assault or deny the identity of the older person
- **Safe, inclusive and flexible:** meets the older person's needs, expectations and rights, and is supportive of diverse characteristics and life experiences
- **Collaborative:** shares meaning, knowledge and experience through meaningful dialogue between the older person and the assessor
- **Self-determined:** provides choice, participation and control to the older person, and allows them to make decisions about matters that affect them



Delivering inclusive aged care booklet

Aged Care Diversity Framework action plans | Australian Government Department of Health, Disability and Ageing

Partners in Culturally Appropriate Care (PICAC)

Working with Diverse Groups in Aged Care

Australian Migrant Resource Centres

12.3.1. Aboriginal and Torres Strait Islander assessment organisations

As a part of the Single Assessment System, Aboriginal and Torres Strait Islander assessment organisations began being rolled out from August 2025. These assessment organisations provide a choice for older Aboriginal and Torres Strait Islander people seeking access to a culturally safe aged care assessment. A small number of organisations will commence providing these services initially and over time, these services will extend their reach and progressively cover more areas across Australia.

A culturally safe assessment process will help to improve the experience for older Aboriginal and Torres Strait Islander people and increase their uptake of aged care services. This will support them to maintain their independence at home for longer.

The organisations will help older Aboriginal and Torres Strait Islander people, their families, and carers, to access aged care services across urban, regional, and remote Australia.

Aboriginal and Torres Strait Islander assessment organisations will:

- Take a less formal yarning approach to assessments to make the older Aboriginal and Torres Strait Islander person feel comfortable.
- Undertake face-to-face assessments, where possible. This could be in the older person's home, at a community centre, or outdoors at a place of the older person's choosing.
- In line with the older person's wishes, welcome the presence of the older person's family member, advocate or registered supporters, to be part of the meetings.
- Allow for multiple visits, if required, to build trust and develop a relationship.
- Be embedded within the local community. Connecting with the local community with their knowledge of local services, customs and protocols will allow them to support matching appropriate assessors to the older person's preferences and needs.
- Be supported by connection to community to gather information about the older person's health and wellbeing to understand the aged care services they need prior to meeting them. This will limit the amount of information that the assessor needs to draw from the assessment, which will help to limit the number of times that the older person needs to re-tell their story.
- Maintain a connection with the older person for the whole journey to receiving services, through Elder Care Support workers. This will help to manage any uncertainty or questions throughout the process.
- Work with organisations that support Stolen Generation survivors, such as the Healing Foundation Peak or seek advice from the Link Up organisations on who is best to support Stolen Generation survivors in your state or territory.
- Provide interpreting services when needed.

Until an Aboriginal and Torres Strait Islander service is available in their area, older Aboriginal and Torres Strait Islander people can receive aged care assessments via an existing assessment organisation. Once an Aboriginal and Torres Strait Islander organisation becomes available, older Aboriginal and Torres Strait Islander people will have the choice to be assessed through either assessment pathway.

More information available at - Aboriginal and Torres Strait Islander Aged Care Assessment Organisations.

12.4. People living with dementia

Under the Statement of Rights in section 23 of the *Aged Care Act 2024* (the Act), an individual has a right to equitable access to an assessment in a manner that is accessible and suitable for individuals living with dementia or other cognitive impairment.

The Australian Government recognises the unique needs of people with dementia and their families, registered supporters or other people who support them. People with dementia can experience communication challenges, which emphasises the need for clear, respectful and effective engagement that is person-centred.

As dementia is a progressive condition, people will require reassessment to respond to changing needs and to plan appropriate, personalised, care and support.

Presumption of capacity

The Act establishes a modern rights-based, person-centred approach that prioritises the safety, health and wellbeing of older people. As such, it places older people and their wishes at the centre of the aged care system.

A key change under the Act is that every older person is presumed to have the ability to make their own decisions and to have those decisions respected and recognised by law. This is known as the presumption of capacity. This means that other people, for example assessors, registered supporters, workers, health professionals and carers, should assume in the first instance that an older person can make their own decisions and do things themselves.

The presumption of capacity applies to every decision to be made. This means that an older person is presumed to be able to make every new decision. If an older person is not able to make a decision on one occasion, it does not mean the older person should be excluded from decision-making on other occasions.

Assessors should implement supported decision-making principles and processes where appropriate, regardless of the presence or absence of a registered supporter, active appointed decision-maker, or other person supporting an older person.

> Note: A diagnosis does not necessarily mean that a person no longer has the ability to make some or all decisions for themselves. This includes diagnoses of dementia, mental illness, intellectual or cognitive disability, or acquired brain injury. For example, simply because a person has been diagnosed with dementia, does not mean that they lack decision-making ability for some or all decisions.

Guidance for assessors

Assessors should foster links with dementia-specific services, including Dementia Australia and Dementia Support Australia (DSA), and build awareness of local memory, cognition and dementia services available, including cognitive or dementia reablement where appropriate. Where relevant, include dementia expertise in the assessment process. This knowledge and connection will assist assessors to better understand the specific needs of people living with dementia and their care partners, families, and representatives, and assist to improve linkages, integrated care, and access.

Assessors should be particularly alert to concerns about cognitive impairment or people who indicate a previous diagnosis of dementia. Referrals to the National Dementia Helpline or a GP should be considered where concerns about cognitive impairment are raised or where there is a diagnosis of dementia but the person, their registered supporters or other people who support them are not receiving the dementia-specific support they need. Information and appropriate interventions after a diagnosis help people to live well with dementia, and plan for the future.

Assessors can request a call back for carers who have concerns about dementia (with their consent) from the National Dementia Helpline through the Assessor Portal and the Aged Care Assessor App. A trained professional from Dementia Australia will then call the carer and speak to them about dementia-specific services and supports that might be of assistance.

People living with dementia can experience behaviour changes, known as behavioural and psychological changes of dementia (BPSD), which impact their care and quality of life. Personalised support services are available from Dementia Support Australia (DSA) to help carers and service providers anywhere nationally to develop strategies that optimise function and support unmet needs for people impacted by BPSD and assessors can make referrals for support (with appropriate consent of the older person and care network as relevant) via DSA's 24-hour helpline or online.

> Note: A person does not need to have a formal dementia diagnosis to be referred to the National Dementia Helpline or Dementia Support Australia.

Assessors must use their professional judgment where an older person has dementia or is cognitively impaired. In these cases, the input of registered supporters or other people who support the older person and/or advocates is particularly important. However, only a person with active, legal decision-making authority for an older person can make a decision on their behalf.

> Note: assessors should be aware that applying professional judgement might be especially difficult when working with Aboriginal and Torres Strait Islander older people and older people from Culturally and Linguistically Diverse backgrounds living with dementia or cognitive impairment. Factors such as language barriers, different concepts around ageing and dementia, a lack of awareness of dementia among family members and the additional stigma attached to dementia in some cultures can all make assessment more complex. Some culturally appropriate dementia resources are included under further information below.

The IAT User Guide provides assessors with prompts to help evaluate cognition throughout the assessment, including aspects related to an individual's functional capacity.

Assessors are required to complete a Dementia specific training module in MAC Learning as part of their training and additional educational resources are available through Dementia Training Australia.

Assessors may find the *Clinical Practice Guidelines* and *Principles of Care for People with Dementia* (the Guidelines) useful. The Guidelines provide recommendations for the diagnosis and management of dementia and are intended for use by staff working with people living with dementia in the health and aged care sectors, including GPs. Updated Guidelines are currently in development.

Companion documents to the Guidelines include a Health Professional Quick Reference Guide, and for people living with dementia and their carers the *Diagnosis, treatment and care for people with dementia: A consumer companion guide.*

Free accredited training, education, upskilling and continuing professional development for the workforce providing dementia care in the primary, acute, and aged care sectors, also accessible for aged care assessors, is available through Dementia Training Australia and the Wicking Dementia Centre.

Further information:

Dementia Australia website:

Home | Dementia Australia

Dementia Support Australia website:

Nationwide, 24-hour dementia carer support | Dementia Support Australia

Department of Health, Disability and Ageing website:

My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships

What we're doing about dementia | Australian Government Department of Health, Disability and Ageing

University of Sydney (Cognitive Decline Partnership Centre) website:

Clinical Guidelines for Dementia

University of Tasmania (Dementia Research and Education Centre) website:

The Wicking Dementia Centre

Dementia Respite Education and Mentoring (DREAM) | The Wicking Dementia Centre | UTAS

Culturally appropriate dementia resources:

Dementia and Aboriginal and Torres Strait Islander people | Dementia Australia

Services for people with dementia from CALD communities | Forward with Dementia

Dementia information in multiple languages | Dementia Australia

12.5. People who live in remote and very remote areas

A small number of older people live in isolated areas. These locations are classified using the Modified Monash Model (MMM). Whilst recognising face-to-face assessment is good practice and should be the first option, this mode of assessment is not always possible for older people living in remote areas. In these circumstances, assessments may be conducted using non-face-to-face technologies such as telephone or telehealth. Where this occurs, a suitably qualified person from within the local health service or community care provider should be present to support the older person and to facilitate the assessment.

Assessors should develop and maintain good working relationships with health and community workers in rural and remote communities who may be called upon to assist with assessments and provide information and community needs and local services.

12.6. People who are financially or socially disadvantaged

Financial or social disadvantage can often create a significant barrier for people to access a wide range of services in the community. Assessors should ensure that they develop and promote links with organisations in their area which attempt to overcome these barriers and provide assessments to people who may benefit from services regardless of their financial or social circumstances.

People who are financially or socially disadvantaged may also experience difficulties in accessing services after their approval. Assessors should be prepared to engage in a wide range of care coordination activities on behalf of older people to ensure that they receive the care which they need and to which they are entitled.

From 1 November, financial hardship arrangements will continue to be available if an older person can't afford to contribute to the cost of their aged care, both in residential care and in-home care. An older person will be assessed on their specific circumstances. If approved for hardship assistance, the Australian Government will pay some (or all) of their aged care fees. The government will pay any approved amounts to the aged care provider on the older person's behalf. If an older person is required to pay some of their fees, they will continue to pay those to their provider.

To apply for financial hardship assistance, an older person must meet certain requirements and complete the Aged Care Claim for Financial Hardship Assistance form. This form is sent to Services Australia to assess the application, and they will let the older person know in writing of their decision and what assistance they are eligible for. This form should be submitted by an older person once they start accessing aged care services.



Hardship assistance for aged care – Fact sheet

Financial hardship assistance | My Aged Care

12.7. Veterans or war widows

The Australian Government recognises the aged care needs of the veteran community, in particular, mental health issues including post-traumatic stress. This is creating demand for a wider range of health care and support services in residential and home care services.

Assessors should establish links with relevant veterans' organisations in their communities and develop links between veterans and home care and residential care services. They should aim to facilitate an understanding of veterans' particular needs and to improve integrated care and access.

Assessors should have a good understanding of services provided by the Department of Veterans' Affairs (DVA) including the Veterans' Home Care (VHC) Program, the Coordinated Veterans' Care (CVC) Program and other mental health and rehabilitation programs.

Assessors should advise veterans that if they are an Australian former prisoner of war or Victoria Cross recipient, DVA will pay their basic fee and means tested care fee. They still may need to pay a means tested accommodation payment if their income and assets are above a certain limit. Services Australia will take into consideration DVA compensation payments when assessing a person's income and assets under the Support at Home program.

Optional learning for all assessors called ‘Supporting older Australians, people with disability and Veterans’ is available through MAClearning.



Department of Veterans’ Affairs website

12.8. People who are homeless or at risk of becoming homeless

Assessors have a responsibility to recognise older people who are experiencing, or are at risk of becoming homeless, and to ensure that they can access an assessment and any aged care services approved for them. Liaisons between assessors and support services for homeless people are particularly important for this cohort because of their extreme vulnerability. Assessments for this cohort will require a flexible and unique approach by assessment organisations. For example, assessors may need to travel to outreach locations in order to undertake the assessment, working closely with the providers already linked to the older person, such as community health clinics, hospitals, emergency housing providers or other community services such as those that provide free meals and laundry services.

People aged 50-64 seeking aged care services under the homeless or at risk of homelessness criteria must meet the appropriate definition as described in Chapter 1 and Chapter 5.

Assessors should also be aware that homelessness alone is not grounds to approve an older person as eligible for residential or other forms of aged care. The person must meet the eligibility criteria set out in the *Aged Care Act 2024*.

Where housing assistance services are not available, assessors should make appropriate referrals and work with their state and territory government housing and homeless services.

Learning for all assessors called ‘Homelessness and older people’ is available through MAClearning.



For further detail on the definition of homelessness in aged care, see Chapter 1 ‘Homeless or At Risk of Homelessness Eligibility’.

12.9. Care leavers

The department's website provides information on care leavers, including a description of the term 'care-leaver.'

This term refers to children who were in institutional and other out-of-home care prior to the year 2000, including:

- Forgotten Australians - people who spent a period of time as children in children's homes, orphanages, and other forms of out-of-home care prior to the year 1989.
- Former child migrants - children who arrived in Australia through historical child migration schemes and were subsequently placed in homes and orphanages.
- Stolen Generations - children of Aboriginal and Torres Strait Islander descent who were taken from their families and communities by Federal and State government agencies and church missions under the forcible removal policies from the late 1800s until the 1970s.

Assessors should be particularly sensitive to the effects of care-leavers' childhood experiences with government officials, authorities and institutional care. These individuals may have experienced complex trauma and have general distrust of institutions and Government departments. Assessors should consider how to best support older people in the most sensitive and respectful way with an awareness and understanding of how childhood experiences may influence their concerns, preferences and decisions in relation to aged care, and emphasise that older people can have a support person at the assessment and that they are not obliged to take up any approved care.

In December 2016, the 'Caring for Forgotten Australians, Former Child Migrants and Stolen Generations resource was launched. This package is designed to enhance aged care services and ensure residential and home care providers provide the best possible care to the care leaver groups. Additionally, the Real Care the Second Time Around Project has developed practical tips to assist aged care providers and staff to engage with Forgotten Australians/Care Leavers.

Important:

Under Support at Home, individuals who are care leavers are eligible for a care management supplement which will be credited to their provider's care management account.

To identify individuals who are eligible for a care management supplement during the assessment, assessors must use the diversity fields in the IAT, which do not currently capture care leavers.

Assessors who have identified individuals who are care leavers during the assessment should select the diversity field 'a person separated from your parents or children by forced adoption or removal'.

This will ensure Services Australia is able to identify these individuals from the assessment and apply a care management supplement to their provider's care management account. Refer to the Support at Home Program Manual for more information on the care management supplement.

Department of Health, Disability and Ageing website: Caring for Forgotten Australians, Former Child Migrants and Stolen Generations Information Package

Helping Hands website: Real Care the Second Time Around – Practical Tips

12.10. Parents separated from their children by forced adoption or removal

This term refers to the policies and practices that resulted in forced adoptions and the removal of children throughout Australia, particularly during the mid-twentieth century.

Forced adoption practices impacted a large number of Australians and caused significant ongoing effects for many people, particularly mothers, fathers, and adoptees.

Assessors need to be particularly sensitive to those older people who have been adopted or impacted by past forced adoption practices, including interactions with government officials, authorities, and institutional care, as these experiences can have significant personal and psychological impacts. Assessors should emphasise that older people' wishes are taken into account, they can have a support person at the assessment, and they are not obliged to take up any approved care.

Department of Social Services website: Families and Children; Forced Adoption Practices and Forced Adoption Support Services

12.11. Lesbian, gay, bisexual, trans, intersex and other gender diverse people (LGBTI)

In Australia, the acronym 'LGBTIQA+' is used widely, however, older people often prefer the use of 'LGBTI,' as the word 'queer' can trigger past trauma as it has previously been used as an offensive derogatory term. 'LGBTI' refers collectively to people who are lesbian, gay, bisexual, trans and gender diverse, and/or intersex. LGBTI is often viewed as and referred to as single category that is used to speak about people using broad generalisations. However, LGBTI communities are not homogenous. Within the LGBTI acronym are several distinct, but sometimes overlapping, demographics each with their own histories, experiences and health needs.

Older LGBTI people and elders are likely to have experienced violence, stigma and discrimination throughout their lives. As a result, they may be reluctant to disclose their identities or histories to aged care services and therefore remain isolated or invisible within both the sector and the broader community. Combined with general stigmatisation and invisibility of LGBTI needs at large, this results in a lack of awareness of the unique needs of older LGBTI people, including a lack of targeted services to support them. In addition, the fear of mistreatment or rejection from aged care providers can lead to older LGBTI people delaying seeking care until their health deteriorates or a crisis occurs.

Assessors should ensure they conduct a non-judgmental assessment and the choice to disclose sexual orientation, sex/gender identity or variations of sex characteristics is entirely the older person's decision. Where an older person does disclose this information, the Assessor should emphasise that their information is protected information under the *Aged*

Care Act 2024. In the case of transgender and intersex older people, where specific medical history may need to be communicated to service providers, it is important to discuss the way this information will be communicated or shared with providers.

Assessors should also be aware of service providers who provide LGBTI-specific services and those that are LGBTI inclusive and be prepared to advocate for LGBTI older people with other service providers as necessary as part of their care coordination activities.

In 2019, Actions Plans to Support LGBTI Elders were developed under the Aged Care Diversity Framework to address the unique needs and challenges faced by older LGBTI people. The provider action plan sets out what aged care providers can do to deliver inclusive care that is appropriate and sensitive to the needs of older LGBTI people. The consumer guide helps older LGBTI people to express their needs when speaking with aged care providers. It can also help people working in aged care to better understand the needs of LGBTI people.



Department of Health, Disability and Ageing website:

Actions to Support LGBTI Elders: A Guide for Consumers

Actions to Support LGBTI Elders: A Guide for Aged Care Providers

Working with Diverse Groups in Aged Care

Federal Register of Legislation website: Aged Care Act 2024 - Federal Register of Legislation (see Statement of Principles section 25)

12.12. Other groups

12.12.1. Carers

It is important for assessors to recognise the valuable contribution and informal support that carers provide in the care of older Australians.

Where possible, with the older person's consent, the assessor should involve the older person's carer, family, registered supporters or other people who support the older person in the assessment and support planning process. In assessing the older person's care needs where family and carers are involved, assessors may find there is a need to balance the older person's concerns and preferences with those of their family and/or carers. Assuming the older person has capacity to make their own decisions, only the goals and preferences of the older person should be reflected in their Support Plan. The assessor may need to meet with the older person separately to ascertain the older person's preferences.

Assessors should (with the older person's consent) gain an understanding of the carer's support preferences for the older person and their capacity to continue in the caring role. Assessors need to consider the carer's circumstances and assess if there are any factors that may affect the sustainability of the caring role. An older person may agree to service recommendations that also benefit the carer, for example a type of respite service where there is an identified area of concern regarding strain in the older person/carer relationship and a goal to relieve stress on the carer.

Assessors should provide information to carers regarding specific support services that are available for carers to access in their own right and inform carers how to link with these support services. Assessors can directly refer carers (with their consent) to Carer Gateway and the National Dementia Helpline through the Assessor Portal and Aged Care Assessor App.



Carer Gateway website.

Department of Health, Disability and Ageing website: Our work related to dementia | Australian Government Department of Health, Disability and Ageing

My Aged Care – Assessor Portal User Guide 2 – Registering support people and adding relationships

For family, friends and carers | **Dementia Australia**

Dementia Support Australia website.

National Dementia Helpline: 1800 100 500 - 24 hours a day, 7 days a week

12.12.2. People living with mental health conditions

When assessing the aged care needs of older people living with a mental health condition assessors are encouraged to liaise with mental health services to assist their understanding of the older person's needs. Assessors can also assist by facilitating links between the older person, providers, and appropriate mental health services.

Aged care services usually do not have the capacity to adequately meet the needs of people with a serious, uncontrolled mental health condition without the support of, and treatment by, mental health services.

Assessment and approval for entry to aged care is only appropriate if the intensity, type, and model of care is the most appropriate to meet the person's care needs. This includes the following considerations:

The person's mental health is stable. If they have recently received treatment, their mental health should be stable prior to being assessed although it is understood they may still have significant symptoms.

- Community mental health services will continue to provide collaborative care for those elderly people who have significant or unstable psychiatric symptoms.

The assessor must, prior to commencing an assessment, obtain informed consent for the assessment either from the older person (if they have the ability to provide this consent), or an appointed decision maker recognised under the Act who has legal authority to provide consent to the assessment. An appointed decision maker must have active, legal authority for the older person. This may include having authority to make decisions regarding health, accommodation, and daily living care.

Involuntary mental health care is governed by separate mental health legislation in each state and territory. People who are placed under some form of an involuntary order (e.g., to manage their medicines when living in the community) may be eligible for aged care services. Assessors should consider each referral on a case-by-case basis.

In some jurisdictions, under certain circumstances, mental health legislation empowers the treating psychiatrist to make accommodation decisions in the best interests of a person receiving treatment under an involuntary order. This power is only exercised when a particular accommodation setting is required to facilitate the treatment of a person's mental health condition. It does not replace the need for guardianship when a mental health condition is incidental to that person's need for placement in residential care.

A comprehensive assessment is also required to access residential aged care facilities in jurisdictions where residential aged care facilities are part of the aged mental health service system.

All assessment organisations should develop assessment protocols that reflect relevant state or territory legislation and regulations, to ensure that older people living with a mental health condition are directed to the responsible agency to assess and recommend services most appropriate to meet their care and support needs.

12.12.3. People with palliative care needs

Under the Statement of Rights in section 23 of the *Aged Care Act 2024* (the Act), an individual has a right to equitable access to palliative care and end-of-life care when required. The strengthened Aged Care Quality Standards also include outcome 5.7 Palliative Care and End-of-Life Care, that provides the intent for providers to follow, including recognising and addressing the needs, goals and preferences of individuals for palliative care and end-of-life care

Palliative care is person and family-centred treatment, care and support for people living with a life-limiting illness. Palliative care aims to improve quality of life and support people to live well for as long as possible.

The Aged Care Quality and Safety Commission stipulate that care recipients are entitled to receive personal and/or clinical care that is appropriate and recognises their needs, goals, and preferences. This is particularly important for care recipients nearing the end of their lives whose preference may be to remain in their home for as long as possible.

Older people with a life-limiting condition can be supported by multiple care systems including, aged care services, mainstream health care services (including specialist care) and state and territory specialist palliative care services.

Where the aged care system is identified as part of the care requirements for a person over the age of 65 years (or over 50 years for Aboriginal and Torres Strait Islander people and people who are homeless or at risk of homelessness) with a life-limiting illness, it is important the aged care assessment is holistic and considers all of the person's needs. An important part of the aged care assessment will be the identification of palliative care and end of life care needs. Timely provision of appropriate care can support people to be cared for in their home for as long as possible if this is their preference. This is therefore important to consider as part of the assessment and when recommending care options and services.

Assessors should pay particular attention and use their professional judgement to note if an older person has a life limiting illness, they would likely benefit from receiving a palliative approach to care.

Supporting information

Palliative care seeks to prevent and relieve suffering through early identification and correct assessment and treatment of pain and other symptoms, associated with a life-limiting illness, whether physical, psychosocial, or spiritual. The types of supports that may be needed by an individual, their families and carers will vary and may include a range of clinical and non-clinical supports.

Palliative care can occur in almost all settings where health and aged care is provided. It may be provided by a variety of professionals, including specialists, general practitioners, nurses, allied health workers, aged care workers, counsellors, and pastoral carers. The assistance of specialist palliative medicine physicians and nurses may be required when a person's symptoms are complex or difficult to manage.

Palliative care is different to 'end-of-life care.' While palliative care may be provided from the point of diagnosis of a life-limiting illness, end-of-life care is care for a person who is in the last months or weeks of life, including for those whose death is imminent (within weeks or days). The needs of patients are higher at this time and timely access to services is vital. Timely access to aged care services may depend on the services being sought and whether a person is already engaged with an aged care program.

It is therefore important to explore all options for an older person, including whether the Support at Home End-of-Life pathway is appropriate. Eligibility for the End-of-Life Pathway can be found in Chapter 6.

The provision of both palliative care and end-of-life care cuts across systems – care offered through the aged care system should be integrated to facilitate seamless transition, building upon clinical palliative care services offered by primary care professionals, or state-based specialist palliative care services.

For example, where a state or territory provides clinical palliative care services in the home, older people receiving palliative care may also require assistance with basic daily living support and supportive care to ensure they are able to remain at home for as long as possible. These care needs range from assistance with daily chores to personal care, providing meals, transport assistance, respite care, home modifications and social support.



Department of Health, Disability and Ageing website:

AN-ACC Class 1 – admit for palliative care

National Palliative Care Strategy

Training and tools for health and aged care professionals

The Australian Government funds accredited education and training on palliative care for the workforce.

The Palliative Aged Care Outcomes Program (PACOP) aims to systematically improve palliative and end-of-life care outcomes in aged care settings in Australia.

End of Life Directions for Aged Care (ELDAC) provides information, guidance, and resources for all aged care staff to support palliative care and advance care planning.



Information can be found at **health.gov.au/palliative-care-education**

12.12.4. Older people who are in prison

Usually, aged care assessments will be conducted when the person is released from prison into the community by referral through My Aged Care. Assessments of ex-prisoners in a community setting will depend on the person's needs and the screening and triage outcome. However, in a prison setting, only clinical assessors can undertake such assessments. A triage delegate can only arrange an assessment by a non-clinical assessor to take place after the person is released.

If it is imperative that an assessment occurs in prison, the clinical assessor can conduct an in-prison assessment, provided the prisoner has a release date and the prison is agreeable to the arrangement. By exception, an older person may be assessed in a prison setting by a clinical assessor prior to them securing a release date. This can only occur in cases where a release date is dependent on a needs assessment being undertaken.

In recognition that prisoners can have very complex health and care needs, it is appropriate for a clinical assessor to be supported by another assessor. This is a decision for the assessment organisation to make keeping in mind the health and safety of its assessors. For additional considerations for WHS screen prior to assessment see Chapter 5.

Regardless of whether the assessment occurs in a community or prison setting, Commonwealth subsidised aged care services can only commence after the prisoner is released. It is the responsibility of the relevant state or territory government to provide the appropriate care and services while the person is incarcerated. If the older person is found eligible for Support at Home, the assessor should update the older person's status to 'not seeking services' at the time of assessment. Upon receiving a prison release date, the older person or registered supporter or other person who support the older person will need to contact My Aged Care to indicate they are actively seeking care to be placed on the Support at Home priority system.

If the person shares (or the assessor is in receipt of) sensitive information, with the older person's consent this can be recorded by adding a sensitive note and/or a sensitive attachment. Providers will be presented with a banner message on My Aged Care where a sensitive note exists prompting them to contact the assessor. The assessor should disclose information where it is applicable to the provider in their provision of care or services to the older person (see Recording sensitive information in Chapter 5). Where it is recorded the older person has challenging behaviours that may impact the safety and welfare of the older person or staff, the assessor should contact the provider to help ensure they can appropriately manage these behaviours once services commence.

The Support Considerations section of the IAT gives assessors the opportunity to ask the older person if there is any further information providers should be aware of in the delivery of care and services. This will allow (although this is up to the older person to agree to) the older person to advise of parole conditions or any implications of their incarceration that relate to effective and safe aged care provision that have not previously been raised during the assessment.

The assessor can record this information as a sensitive note and/or sensitive attachment and should add a note in the Support Considerations section of the IAT (and only if appropriate, the Support Plan) indicating that there is a sensitive note and/or sensitive attachment to view.

Assessors should be mindful that there is an increased likelihood that prisoners or ex-prisoners are at risk of vulnerability and complexity and requiring additional linking support (see Delivering Linking Support / Care Coordination to Vulnerable Older people in Chapter 5: Assessment activities).

> Note: When assessing an older person in a prison setting for services to support their transition to residing in the community, the assessor can still complete a 'true' assessment based on their best efforts to understand and assess against the person's functional needs in the community setting they intend to reside in, not the setting where the assessment is being carried out. Where a person is not in the setting they plan to reside in, it may be necessary for assessors to seek information about the older person's home environment from the older person's care and support team to make an as accurate assessment as possible of their functional needs.

13. Chapter 13: Operating procedures

What you'll find in this chapter

This chapter includes information on privacy, information management and relevant legislation. Also included in this chapter is information about:

- Applying to be delegate
- Information management
- Clinical governance
- Branding
- Resources for consumers
- Reporting and performance

13.1. Applying to be a delegate

Delegate applications are submitted online within the My Aged Care assessor portal. There are currently three delegate positions:

- Triage delegate,
- Clinical assessment delegate and
- Non-clinical assessment delegate.

13.1.1. Delegate on/off form

To be appointed to a delegate position, such as a triage delegate or assessment delegate and gain the authority to make approval decisions, individuals must complete an application process and be approved by the Department of Health, Disability and Aged Care (the Department). This application is submitted through the My Aged Care assessor portal.

> Note: All non-clinical and clinical assessors have delegation under the Instrument of Delegation to approve CHSP, CHSP AT, CHSP HM when completing a home support assessment. In practice, even though there is a blanket delegation, assessment organisations can instruct their workforce to get someone else to approve a client's home support assessment.
>
> From 29 June 2026, the non-clinical delegate workflow will be completed through the Assessor Portal. To undertake delegation, all non-clinical delegates must hold the appropriate non-clinical delegate role in the Assessor Portal from this date

A learner assessor must not be appointed as a clinical or non-clinical delegate until they have completed all mandatory training requirements set out in the My Aged Care Workforce Learning Strategy and been issued with a completion certificate on MAClearning.

Within the portal, the Delegate on/off form can be used to:

- **Add** users to delegate positions.
- **Cease** existing delegates from delegate positions.
- **Replace** existing delegates noting that the replace functionality will cease existing delegate access and add their replacement in a single step.

A number of rules apply:

- Only assessors, team leaders, and delegates can hold delegate positions.
- To apply on behalf of someone else, the applicant must be either a Team Leader or an Assessment Organisation Operational Manager.
- Team Leaders can submit applications for themselves as well as for others.
- Assessment Organisation Operational Managers can only hold a delegate position if they are also an assessor or a Team Leader.

All approved delegates are assigned a unique Delegate ID in the My Aged Care system. This ID consists of a 6-character code, where:

- The first three characters represent the assessment organisation ID
- The fourth character indicates the profession ID
- The final two characters identify the specific position within the organisation.

Delegate ID Position setup

The Delegate Position framework derives the position name (Delegate ID Position) for all delegate roles as the concatenation of: 'Initials of delegate role + delegate team ID + profession code + position number'

Initials of delegate role

Table 57. Initials of Delegate Roles

Delegate Role	Initials of Delegate Role
Triage Delegate	TD
Clinical Assessment Delegate	blank (no value)
Non-Clinical Assessment Delegate	NCAD

Delegate team ID

The delegate team ID is an existing field and is unique to an outlet.

Profession code

Table 58. Profession codes

Profession	Profession Code
Non-Clinical	0
Medical Practitioner	1
Registered Nurse	2
Social Worker	3
Occupational Therapist	4
Physiotherapist	5
Other Health Professional	6
Psychologist	7

Position number

The position number is a counter, automatically incremented.

Example:

A Triage Delegate role for an outlet with:

- Delegate Team ID: "7YC"
- Profession: Social Worker (Profession Code: "3")
- Position Number: "00"

The Delegate Position ID will be TD7YC300.

A Clinical Assessment Delegate position (ID: 6SR315) is located in Southern Tasmania (Aged Care Planning Region) for the Tasmanian Department of Health. This role:

- Can only be occupied by a Social Worker
- Is identified by the Position Number: 15 in that outlet.

Using the My Aged Care assessor portal

The My Aged Care assessor portal allows applicants to manage delegate positions through a structured process.

The delegate application process consists of four main steps:

- Create the application – The applicant initiates and submits the application.
- Verify the application – A verifier, who must hold the Team Leader role in the portal, reviews and confirms the application details.
- Support the application – A supporter, who must hold the Assessment Organisation Operational Manager role in the portal, provides the final approval or endorsement.
- Approve the application – The Department reviews the application and any supporting evidence before deciding to approve or deny it.

Each step in the application process must be completed in order, following the system's established rules and workflows.

Portal processes

A key requirement is that applications progress one step at a time. For instance, if a Team Leader submits an application on behalf of another user, they must first create and submit the application. Only after submission can they return to verify it. This structured approach ensures clarity and organisation throughout the process.

Applicants, verifiers, and supporters have access to the proposed delegate's profile details, including their name, contact information, clinical status, occupation, and qualifications. However, these details cannot be updated during the application process. If any information needs to be changed, the applicant must work with the outlet or organisation administrator to update the details within the portal, separately from the application process.

Access to applications is limited to authorised users

Outlet-level Team Leaders and Outlet Administrators have limited access. For applications involving multiple outlets, only Team Leaders overseeing all included outlets can view them. Outlet Administrators have similar restrictions and, like Organisational Administrators, do not participate in processing delegate applications.

Creating a delegate application

When creating a delegate application, delegate positions can be managed by adding, replacing, or ceasing delegates.

- The **Add** option allows the user to create a new delegate position.
- The **Replace** option lets the user cease an existing delegate and assign their replacement.
- The **Cease** option is used to remove a delegate from their positions without assigning a replacement.

Each application must focus on a single delegate role, which must be selected at the time of submission. The available roles are Triage Delegate, Clinical Assessment Delegate, or Non-Clinical Assessment Delegate.

If someone is required to hold multiple roles, separate applications must be submitted for each role. In replace applications, the new delegate automatically inherits the same role as the ceasing delegate.

Important to note

- For Add and Replace applications, selecting the delegate's profession is a key step. The system uses this information to either assign an existing vacant position for that profession or create a new position if no vacancy exists. For Cease applications, there is no need to select a profession. Simply choose one or more positions the delegate currently holds to proceed with their cessation, regardless of their profession.

- Applicants can include start and end dates in their applications. The Date From field specifies when the delegate will begin their role, while the Date To field is used to automate the delegate's dissociation when their term ends. However, the Date To field is not needed for ceasing a delegate, as both temporary and permanent cessations are treated the same by the system.

- As part of the process, applicants must nominate a Team Leader to verify the application and an Assessment Organisation Operational Manager to support it. The system filters the list of eligible Team Leaders to include only those who cover all outlets involved in the application. If no suitable Team Leader is available, the system will display an error message. The Operational Manager must also be selected from the provided list to ensure their role matches the application's requirements.

- Special rules apply when a Team Leader submits their own application. In such cases, they must nominate another Team Leader to verify it. Once submitted, the nominated verifier will handle the next steps.

- The system automatically checks several details during the application process, including the proposed delegate's clinical status, occupation, and qualifications. If the delegate does not meet the criteria, warning messages will guide the applicant to update the delegate's user profile or adjust their position type or profession. Applicants can still proceed by acknowledging these issues, and this acknowledgment will be visible to the verifier and supporter in the next stages. Some issues, however, are considered hard stops. For example, if the delegate lacks a clinical status or is assigned a role incompatible with their profile, the application cannot proceed until their user profile is updated.

Note:

The department’s My Aged Care Capability Section verifies each application to ensure all required training has been completed.

For details on mandatory training requirements for each position, please refer to the My Aged Care Workforce Learning Strategy v1.5.

- Supporting documentation to be uploaded with the application could include MAC learning training transcripts, qualifications, AHPRA registration evidence etc.

- Once the application has been submitted, a confirmation banner will appear confirming that the application has been created and submitted to the verifier for action.

- Under exceptional circumstances, non-clinically qualified staff within Aboriginal and Torres Strait Islander assessment organisations with extensive aged care experience and trusted by community could submit a business case to be considered for the clinical assessor or/and Triage delegate roles.



My Aged Care Workforce Learning Strategy.

Assessor Portal User Guide 12 – Managing Delegate Roles

13.2. Information management

13.2.1. Privacy and Protected Information under the *Aged Care Act 2024* (Cth)

Sections 537 to 541 of the *Aged Care Act 2024* (the Act) specifies the purposes for which information can be used or disclosed in accordance with the Act. The collection of information from an older person, their registered supporter(s) and/or appointed decision maker/s for the purposes of determining an individual's eligibility and assessing their access to funded aged care services is authorised by the Act.

Personal information collected during the assessment process is considered protected information. Protected information is defined under section 21 of the Act, as personal information or information, including commercially sensitive information, where the disclosure of which could reasonably be expected to found an action by an entity (other than the Commonwealth) for breach of a duty of confidence. Personal information has the same meaning as in the *Privacy Act 1988* (Privacy Act) and is defined as information or an opinion about an identified individual, or an individual who is reasonably identifiable:

- Whether the information is true or not; and
- Whether the information or opinion is recorded in a material form or not.

Additionally, information collected during the assessment process may also be considered sensitive information as defined by section 6 of the Privacy Act which includes information about an individual's identity and health. Sensitive information within the meaning of the Privacy Act may be personal information (information is not personal information if it is only about a person who has died.) Sensitive information is afforded additional protection under the Australian Privacy Principles (APP) and should only be used for authorised purposes (see information below about assessment organisations who may be APP entities.

The *Aged Care Act 2024* (the Act) imposes strict rules on the management of protected information, stating that a person commits an offence if they make a record of, disclose, or otherwise use protected information that was acquired in the course of performing duties or exercising powers or functions under the Act or the *Aged Care (Transitional Provisions) Act 2024,* where the use or disclosure is not authorised under Division 2 of Part 2 of Chapter 7 of the Act. The maximum penalty for such an offence is imprisonment for up to two years or a fine of 120 penalty units, or both.

To comply with these requirements, individuals and entities who handle assessment information must implement stringent confidentiality measures. This includes secure handling, recording, and storage practices to ensure that the information is safeguarded against unauthorised access or disclosure.

To ensure the proper handling and disclosure of protected information in accordance with the law, assessment organisation staff must follow their organisation's standard operating procedures and guidance in this manual.

Assessment organisations who are APP entities under the Privacy Act will also need to comply with the requirements of the Privacy Act in handling personal information. Where personal information is used or disclosed in accordance with an authorisation in Division 2, Part 2, Chapter 7 of the *Aged Care Act 2024* this will be permitted under the *Privacy Act* (see APP 6.2(b)).

Assessment organisations should consult the Privacy Act and APP Guidelines for further information on the definition of APP entities and its applicability to their organisation.

13.2.2. Collection and protection of information

The collection of information about an older person and their support network as part of the assessment process must comply with the legislative requirements under the *Aged Care Act 2024* and *Privacy Act 1988* (the Privacy Act). Where applicable assessors must seek and gain informed consent using the My Aged Care Assessment Consent Form (the Consent Form) including reading the consent scripts to the older person or their appointed decision maker recognised under the Act (whether or not they are a registered supporter).

Any information collected for the purpose of determining an individual's eligibility and need for Commonwealth-subsidised aged care is collected on behalf of the Commonwealth and is therefore Commonwealth property. This includes any notes, documents or other materials created for the purpose of preparing an older person's record.

The Privacy Act contains further provisions to protect information which applies to assessment organisations.

Where the Privacy Act applies, it is critical that assessment organisations have systems, protocols and processes in place to ensure the safety of older people's records from loss, interference, misuse, unauthorised access, modification or disclosure. This requirement relates to Australian Privacy Principle 11. Penalties may apply to agencies and individuals for breaches of the Privacy Act. Assessment organisations may refer to the Office of the Australian Information Commission for further information on the handling of personal information and the consequences of misuse.

If a record of an assessment is a state or territory government as well as being a Commonwealth record, there may be further requirements to retain and store information under state or territory legislation. Assessment organisations should seek advice from their state or territory government on any state or territory requirements. Assessment organisations must meet all requirements at both levels of government.

All assessment organisation staff should exercise caution and care when handling personal information. If an assessment organisation staff member becomes aware of a potential privacy breach, they must discuss this with their assessment organisation manager and follow their organisation's procedures.

13.2.3. Use, storage and retention of information

Records are now created, stored and managed electronically in the My Aged Care portal. In some circumstances, it may be necessary for records to be created in a hard copy paper format (e.g., the Emergency Residential Care - Application for Care form). In these cases, the paper records are to be uploaded to the My Aged Care portal as soon as possible and the paper copy destroyed in accordance with the destruction guidelines (see Destruction below).

Should you require information about the management of legacy records, those records that were created prior to the My Aged Care Gateway please contact your assessment organisation manager who can liaise with the department if necessary for further advice.

13.2.4. Destruction of information

The destruction of new paper records should be undertaken as soon as the record has been captured digitally in the My Aged Care portal, and a true electronic copy has been confirmed. Destruction can be undertaken using class B paper shredders that shred to P-5 security level. Level P-5 provides more security with cross-cut shreds that are only ≤ 30 mm² particles with width ≤ 2 mm.

Alternatively, destruction can also be through a Protective Security Policy Framework endorsed T4 accredited waste management agency.

The destruction of electronic records requires the deletion of all copies of the record from any system in such a way that it is impossible to restore the record. For records that are destroyed and not uploaded to My Aged Care, assessment organisations must also maintain evidence of identifying what has been destroyed and the means of destruction.

 **Department of Home Affairs website:** Protective Security Policy Framework

13.2.5. Use and disclosure of information

Assessors and other staff must be aware that information they acquire or generate in the course of performing their delegated functions or powers under the *Aged Care Act 2024* (the Act) may not be recorded or disclosed or otherwise used unless it is in accordance with the Act. Generally, information can be used or disclosed by assessors and staff in the course of performing their delegated powers or functions under the Act or with the consent of the older person. Written records of 'interesting cases' may not be kept by staff members, and cases may not be referenced in public discussion such as in a Letter to the Editor or in social media. There are explicit authorisations for the use and disclosure of information under the Act. These may generally be categorised as:

- **general authorisations**- including but not limited to functions and powers under the Act, for proceedings, with consent, preventing serious threat to safety, health or wellbeing, for the purposes of worker screening
- **entrusted persons** – disclosure to a minister, disclosure for the purposes of obtaining legal advice or another legal service, for the provision of services to an individual (but only for specific purposes, such as assessing the level of care an individual needs, relative to the needs of others)
- **authorisation by the System Governor or Appointed Commissioner** – disclosure to relevant Commonwealth bodies and agencies, disclosure to a registered supporter of an individual accessing or seeking access to funded aged care, disclosure for continuation of funded aged care services, disclosure for research, disclosure for law enforcement and revenue protection, disclosure for maintenance of professional standards, disclosure for certified purposes
- **authorisation by the System Governor or Appointed Commissioner for certain inquiries**- disclosure to the coroner, disclosure for state or territory complaints
- **Authorisation by the System Governor for grants and quality purposes**- disclosure for grants and disclosure for star ratings

Disclosures made under any of the authorisations must be in accordance with the specific requirements outlined under Division 2 of Part 2 of Chapter 7 of the *Aged Care Act 2024* (the Act).

Any systems developed for the collection and analysis of data should incorporate adequate procedures to protect the privacy of people being assessed. If data is to be used for purposes other than assessment, or individual care planning, assessors must have procedures in place to ensure that older person confidentiality is maintained and individuals cannot be identified.

Older people and their registered supporters should be encouraged to access their My Aged Care online account. This gives direct access to the older person's assessment information, which they can disclose to other parties as they wish.

In cases where there is no consent to release information or any doubt about the release of information, the assessor should discuss this situation with the organisation's manager. The manager may further consult the assessment organisation's auspice organisation, the state or territory government, the department or obtain independent legal advice if any doubt remains, before releasing information.



Australian Security Intelligence Organisation website: ASIO T4 Protective Security

Federal Register of Legislation website: Aged Care Act 2024 - Federal Register of Legislation

Archives Act 1983

Electronic Transaction Act 1999 (see Part2, Division 2, Section 12 – Retention)

Privacy Act 1988 - Federal Register of Legislation

National Archives of Australia website: Records Authority 2011/00396196 Department of Health and Ageing (includes Aged Care)

Office of the Australian Information Commissioner website:

Australian Privacy Principles

13.2.6. Freedom of information

The Commonwealth *Freedom of Information Act 1982* (Freedom of Information Act) gives members of the public the right to request access to government-held information. This includes information the government holds about individuals or about government policies and decisions. The Freedom of Information Act extends, as far as possible, the right of the Australian community to access information (generally documents) in the possession of the Commonwealth, limited only by considerations of the protection of essential public interest and of the private and business affairs of persons in respect of whom information is collected and held by departments and public authorities.



Federal Register of Legislation website: Freedom of Information Act 1982

Office of the Australian Information Commissioner: What is freedom of information? | OAIC

13.2.7. Framework for Governance of Indigenous Data

The Framework for Governance of Indigenous Data provides a stepping stone towards greater awareness and acceptance by Australian Government agencies of the principles of Indigenous Data Sovereignty.

The Indigenous Data Sovereignty Principles are outlined by the Maiam nayri Wingara Indigenous Data Sovereignty Collective. The principles concern the right of Aboriginal and Torres Strait Islander people to exercise ownership and control over Indigenous data at all phases of the data lifecycle. Indigenous data is defined by Maiam nayri Wingara as 'information or knowledge, in any format or medium, which is about and may affect Indigenous peoples both collectively and individually.'

The framework contains the following guidelines for Australian Government agencies to change data governance practices, in alignment with the commitments made in the National Agreement on Closing the Gap:

- **Partner with Aboriginal and Torres Strait Islander people-** establishing formal partnerships and shared decision-making with Aboriginal and Torres Strait Islander people, embedding Indigenous leadership into data governance.
- **Build data-related capabilities-** Supplementing of technical skills with understanding of the ways in which Indigenous data has been collected and the narratives and challenges which arise from current datasets. Supporting Aboriginal and Torres Strait Islander communities and organisations through training and up-skilling Indigenous people.
- **Provide knowledge of data assets-** Supporting Aboriginal and Torres Strait Islander people to locate and access relevant government held data by informing Indigenous people about what data is held by the government, its usage and access permissions.
- **Build an inclusive data system-** The structural transformation of datasets to support the inclusion of Aboriginal and Torres Strait Islander people in data governance.



OAIC - the Privacy Act

Framework for Governance of Indigenous Data

13.3. Clinical governance

Assessment organisations have a responsibility to implement effective clinical governance, made operational through a clinical governance framework. A clinical governance framework is a framework that describes an organisation's approach to clinical governance. It must include the practical, clinical supports that are in place for staff who may need to exercise clinical judgement or undertake elements of an aged care needs assessment that are clinical in nature.

Appendix C provides guidance on how to implement effective clinical governance.

13.4. Separation of assessment services and delivery of aged care services

13.4.1. Conflict of Interest in assessment services delivery

Assessment organisations that deliver Commonwealth-funded aged care services must declare, and are required to outline, to the Commonwealth's satisfaction and approval, how any perceived, potential or real conflicts of interest in the delivery of aged care assessment services will be managed and mitigated. This also applies to any related entities.

It is possible that an older person may be referred to a service provider of a related entity to the assessment organisation for Commonwealth-funded services, particularly when there are no other service providers operating in the same area as the older person.

Strategies and mitigations that the department considers when identifying and determining acceptance of an assessment organisation's conflict of interest includes but is not limited to:

- adequate separation of workforce through separate physical premises;
- separate team and management structure;
- separate IT systems;
- conflict of interest policies and processes and awareness through staff training;
- employee declarations prior to and during employment;
- internal audit programs.

Assessment organisations have an obligation to report any conflict of interest to the department, and must make full disclosure of a conflict and provide the steps it proposes to take to resolve or otherwise deal with the conflict of interest to the satisfaction of the department.

If the department is not satisfied that a conflict is being managed appropriately under the contract, the department has options including:

- withholding or revoking approval of an assessment organisation's approval to provide Commonwealth-funded aged care services in the same Service Area as it is delivering assessment services
- reasonably requiring the assessment organisation to take steps to resolve or otherwise deal with the conflict of interest
- as a last resort, termination of contract.

13.4.2. Separation of assessment services and delivery of aged care services

An assessment organisation delivers the assessment of older person needs independent of provider preferences, and ensures older people are referred only to the services that will fulfil their needs and goals.

It is a requirement for assessment organisations to contractually have operational separation of assessment services from service delivery (where applicable) for all contracted assessment organisations and any relevant sub-contractors (including consortiums).

Assessment organisations that deliver both assessment services and service delivery must ensure there is a clear separation of service, particularly in the facilitation and management of assessments and referrals to aged care services. Assessment organisations must have policies and procedures in place to assure the separation of assessment from service delivery**.**

Assessment organisations must seek prior approval from the Department of Health, Disability and Ageing (the department) before engaging or using assessment organisations and any relevant sub-contractors to provide aged care services.

13.5. Branding

Assessment organisations that are contracted to (or in an agreement with) the Australian Government (under the oversight of the department) are required to comply with branding guidance that is included in the following style guides:

- Ensure all materials produced adhere to the Australian Government Branding Guidelines.
- Ensure all web-based content complies with the relevant Digital Service Standards including Requirements for Australian Government websites and comply with the Web Content Accessibility Guidelines (WCAG) version 2.2 AA for all government websites. http://www.w3.org/TR/WCAG

Subcontractors are required to consult with their primary contractor on branding requests.



- **Department of Prime Minister and Cabinet website:** Australian Government Branding Guidelines | PM&C
- Digital Service Standards
- Web Content Accessibility Guidelines (WCAG) 2.2

13.6. Aged care resources for older people

Hard copies of My Aged Care resources including booklets, brochures, posters and magnets are available from National Mailing and Marketing by emailing: health@nationalmailing.com.au or calling (02) 6269 1025.

Information and resources about aged care can be found on the My Aged Care website. Recommended information and resources include:

- *Exploring aged care* booklet for older people, their families and carers.
- Signing up to receive the EngAged, our monthly newsletter on aged care and ageing well.
- Learn more about the Council of Elders and stay up to date with their work.
- Find out what the Department of Health, Disability and Ageing is doing to help people in Australia age well.



Resources | My Aged Care

Exploring aged care booklet

EngAged newsletter: health.gov.au/aged-care-newsletter-subscribe

Aged Care Council of Elders | Australian Government Department of Health, Disability and Ageing

health.gov.au/topics/positive-ageing-is-ageing-well

13.7. Reporting and performance

Assessment organisations are expected to meet measures on timeliness and performance according to their contractual agreements with the Australian Government.

The department makes available various business intelligence (BI) and management reports which support assessment organisations in monitoring and managing their performance against agreed KPIs and other measures. These reports are progressively becoming available during the establishment of the Single Assessment System workforce. Assessment Organisations can access Qlik reports on the Health Data Portal, reports currently available include:

- SAW001: Referral and Assessment Volumes
- SAW 002: Timeliness
- SAW003: Outstanding Assessments
- SAW005: Organisation Performance
- SAW006: Recommended Services
- SAW007: Service Referrals
- SAW008: Home Care Package Approvals
- SAW 009: Referral Data Breakdown
- SAW010: Assessment Data Breakdown
- SAW011: Support Plan Reviews
- SAW012: Assessment Overview
- SAW013: Aged Care Workforce Information
- SAW014: Linking Support
- SAW015: Reablement

As further reports become available, they will be communicated to Assessment Organisations and listed above. The department also publishes a monthly report of organisations' performance by mid-month following the end of the reporting period.

For queries regarding the Single Assessment System Qlik reports, support documentation or assistance with access to the Health Data Portal, please contact AgedCare.Assessment.Reporting@health.gov.au

13.8. Assessor ID Cards

The Aged Care Rules 2025 and the Aged Care Act 2024 (Act) require the department to provide identity cards to approved needs assessors and set out requirements for the content of such. Section 343A-5 of Chapter 11 Part 2 of the Rules outlines the requirements of an approved needs assessor identity card, including how the identity card must satisfy the requirements of the Act prescribed by this section (this applies to both aged care needs assessors and residential aged care funding assessors). The requirements include the organisation name, full name of the assessor, the organisation's logo, the Commonwealth Coat of Arms, an expiry date, a serial number, the size of the card, and specific phrasing to confirm the assessor is approved and able to conduct assessors. It is a requirement for all aged care needs assessors to carry and produce their identity cards if requested.

14. Chapter 14 – Fees and payments

What you'll find in this chapter:

This chapter provides guidance on:

- fees,
- payments, and
- participant contributions for funded aged care services.

14.1. An assessor's role in advising clients about fees and payments

It is important that older people understand the potential costs of care early in their interaction with the aged care system.

Assessors are not responsible for providing detailed financial information about the fees or charges that an older person may be charged to access aged care services, but they do have a role in advising older people about where they can access the information, they need and what the process may entail. They should be able to assist clients to access appropriate support should an older person be experiencing financial disadvantage (see section 14.2.4 Financial Hardship).

Ideally, clients should be referred to the My Aged Care website and the contact centre for information regarding care costs and fees prior to the face-to-face assessment. This gives the client time to consider the information prior to the assessment.

Note:

After the assessment, rather than the assessor handing out Services Australia hard copy forms to the client (which may lead the client to complete a form unnecessarily), assessors can leave booklets specific to their service recommendations which contain necessary fee information for that program or type of care.

Assessors may wish to point out the section of the booklet which provides information about fees, who to contact about whether they need to complete a form and how to access the forms if required (see Chapter 13).

14.2. Aged care program fees

14.2.1. Fees for Commonwealth Home Support Program (CHSP)

A provider delivering funded aged care services through a service group under the CHSP may charge an individual an amount for or in connection with those services (the CHSP

client contribution), in accordance with section 286 of the *Aged Care Act 2024*. Providers must have a publicly available financial hardship policy that covers how clients can apply for a waiver or reduction of the CHSP contribution.

Clients are exempt from paying a client contribution towards any *Hoarding and squalor services* they may receive. If the client requires other CHSP services (e.g. meals) they would be expected to pay a client contribution for that service.

Support at Home participants must pay CHSP client contribution fees like other CHSP clients. Support at Home participants cannot use their budget to pay the CHSP client contribution.

The CHSP contribution must be agreed with the client in writing, including how and when it is to be paid and outlined in the client's Service Agreement. In agreeing to the amount of CHSP contribution, providers should consider a range of factors including:

- business costs associated with delivering the service
- affordability for CHSP clients
- the socioeconomic circumstances of those receiving services.

There is no formal means testing for CHSP client contributions. The client contribution fee may vary from person to person. This is because the fee can vary depending on the specific services a client receives and their individual capacity to pay. Two clients of a similar age with similar support needs may pay different CHSP contributions for a similar service.

The National CHSP Client Contribution Framework outlines the principles that service providers can adopt in setting their client contribution policies with a view to ensuring that those who can afford to contribute to the cost of their care do so whilst protecting those most vulnerable.



Commonwealth Home Support Program (CHSP) 2025–27 Manual (from 1 November 2025) | Australian Government Department of Health, Disability and Ageing

Commonwealth Home Support Program (CHSP) resources

14.2.2. Fees for Support at Home participants

The introduction of contributions in the Support at Home Program have replaced fee arrangements under the Home Care Package Program.

With the transition from the Home Care Package program to Support at Home, changes have been made to how participant contributions are calculated. This information is applicable for older people accessing services under the Support at Home Program, including through the Restorative Care Pathway, End-of-Life Pathway and Assistive Technology and Home Modifications (AT-HM) scheme.

For Support at Home participants, an income and assets assessment by Services Australia determines participant contributions. Contributions will be different for each participant based on the type of service received, the outcome of their income and assets assessment and their pension status.

- Clinical support services will attract no contribution fees as they are fully funded by the government for all participants.
- Independence services such as transport will attract moderate contributions.
- Everyday living services such as cleaning and gardening will attract the highest contributions.

For full or part pensioners, Services Australia will use the information on a person's income and assets assessment that has been provided for their pension assessment to determine their Support at Home contributions. Non-pensioners, once approved for Support at Home will need to complete an income and assets assessment if Services Australia does not already have their financial details.

Completing an income and assets assessment is not mandatory, however, Support at Home participants who choose not to complete one can be asked to pay the maximum participant contribution rate.

Providers do not need to wait for an income assessment to be completed before an older person commences Support at Home services. Service providers and participants can agree on a temporary contribution rate while a new participant's income and assets are being assessed by Services Australia. The Support at Home fee estimator, available on the department's website can be used to assist in determining these temporary rates.

A no worse off principle applies for grandfathered Home Care Package care recipients who, on or before 12 September 2024, were either receiving a Home Care Package, on the National Priority System or assessed as eligible for a package. The no worse off principle applies to financial contributions. These participants will make the same contributions, or lower, than they were assessed as having to pay under Home Care Package Program arrangements, even if they are reassessed into a higher Support at Home classification at a later date. The same lifetime cap will also be honoured for this cohort (approximately $85,000).

For Support at Home Participants there are defined circumstances when they may simultaneously access CHSP services. When doing so, a Support at Home participant must pay CHSP client contribution fees. The Support at Home participant will need to fund the client contribution fees themselves and cannot use their Support at Home funding allocation. This also includes the following services:

- Pre-existing CHSP social support group
- Short-term planned respite
- Urgent services
- Specialised support (Vision advisory services)

Restorative Care Pathway

Participant contributions apply for services delivered in the independence and everyday living categories. Services in the clinical support category do not require participant contributions and are fully funded by the government.

AT-HM Scheme

Support at Home participants may be required to make contributions for AT-HM items and services. AT-HM items attract a contribution rate equivalent to the independence category. Prescriptions and wrap-around services fall under the clinical supports category, requiring no participant contribution.

End-of-Life Pathway

Consistent with ongoing Support at Home, participant contribution arrangements apply for independence and everyday living services accessed under the End-of-Life Pathway. For services in the clinical supports category, no participant contribution is required as these services are fully funded by the government.



Further information is available on the Department of Health, Disability and Ageing website:

- Support at Home Participant contributions
- Support at Home Program Manual
- Schedule of Fees and Charges for Residential and Home Care

My Aged Care Website:

- Aged Care Resources
- Fact Sheet: Support at Home program - participant contributions

Services Australia website:

- Providing home care
- Providing residential care

14.2.3. Older people entering permanent residential care

How much a person pays for their residential aged care is based on their income and assets. Services Australia or the Department of Veterans' Affairs (DVA) assesses income and assets, and this is known as an aged care means assessment. If an older person is a member of a couple, they will be assessed on half of their combined income and assets. Residents who have had their means assessed are required to report changes to their financial circumstances to Services Australia or DVA within 28 days to help keep their fees correct.

People who can't afford to make a higher contribution will only pay the basic daily fee. Those who can afford to will contribute more to their aged care costs.

If an older person chooses not to have their means assessed, they will not be eligible for assistance with care and accommodation costs.

If a person moves into an aged care home for permanent residential care, they will pay fees under one of 2 arrangements:

- **1 July 2014 fee arrangements:** these apply for people who were approved for or accessing a Home Care Package on 12 September 2024, and who are therefore protected by the 'no worse off principle" and will pay fees under the 1 July 2014 arrangements.
- **1 November 2025 fee arrangements:** these apply to people who first enter residential care on or after 1 November 2025.

1 July 2014 fee arrangements

Residents under these arrangements are not affected by the changes to means assessments under the *Aged Care Act 2024*.

Before entering into permanent residential care, an older person should have their means assessed to see if they're eligible for Australian Government assistance with fees and accommodation costs. The fees they pay will depend on the outcome of their means assessment and what they agree on with their aged care provider. Residents can also submit an *Aged care calculation of your cost of care form* after entering aged care.

All fees must be clearly written in the resident or service agreement, accommodation agreement and the optional higher everyday living agreement.

An older person may need to pay some or all of these fees:

- basic daily fee
- means tested care fee
- accommodation costs
- fees for optional services.



Understanding fees for aged care homes – 1 July 2014 fee arrangements | Australian Government Department of Health, Disability and Ageing

Means assessment for residential aged care | Australian Government Department of Health, Disability and Ageing

1 November 2025 fee arrangements

Residents who have entered care after 1 November 2025 are affected by means assessment changes under the *Aged Care Act 2024.* These include:

- new income and asset limits will determine the new means tested fees
- the hotelling supplement will be means tested rather than paid in full by the government, and some residents will contribute to it with a hotelling contribution
- some residents will pay a new means tested non-clinical care contribution with daily and lifetime caps.

Before entering permanent residential care, an older person should have their means assessed to see if they're eligible for Australian Government assistance with fees and accommodation costs. The fees they pay will depend on the outcome of their means assessment and what they agree on with their aged care provider. Residents can also submit an *Aged care calculation of your cost of care form* after entering aged care.

All fees must be clearly written in the service agreement with the provider, accommodation agreement and the optional higher everyday living agreement. These fees may change over time during the time of an older person's care.

Older people may need to pay some or all of these fees:

- basic daily fee
- hotelling contribution
- non-clinical care contribution
- accommodation costs
- higher everyday living fee.



Understanding fees for aged care homes – 1 November 2025 fee arrangements | Australian Government Department of Health, Disability and Ageing

Means assessment for residential aged care | Australian Government Department of Health, Disability and Ageing

14.2.4. Financial hardship

Financial hardship arrangements available if an older person can't afford to contribute to the cost of their aged care, both in residential care and in-home care. An older person will be assessed on their specific circumstances. If approved for hardship assistance, the Australian Government will pay some (or all) of their aged care fees. The government will pay any approved amounts to the aged care provider on the older person's behalf. If an older person is required to pay some of their fees, they will continue to pay those to their provider.

To apply for financial hardship assistance, an older person must meet certain requirements and complete the Aged Care Claim for Financial Hardship Assistance form. This form is sent to Services Australia to assess the application, and they will let the older person know in writing of their decision and what assistance they are eligible for. This form should be submitted by an older person once they start accessing aged care services.

Hardship assistance for aged care – Fact sheet

Financial hardship assistance | My Aged Care

14.2.5. Fees payable by older people accessing care under the MPSP

Under the MPSP, a provider may charge older people a specialist aged care program fee which is intended to help cover the costs of daily living like meals, cleaning, laundry, heating and cooling. Providers can decide the amount payable at their discretion, but it cannot be more than the amount agreed between the registered provider and the individual in a written agreement.

The fee cannot be more than:

- 85% of the basic age pension amount (worked out on a per day basis) for residential care, or
- 17.5% of the basic age pension amount (worked out on a per day basis) for home support, assistive technology or home modifications services.

The Rules also require that the provider has a financial hardship policy which must be considered when charging any specialist aged care program fee.

For ongoing residential care, in some circumstances, the provider can charge an accommodation payment to cover the costs of a resident's accommodation.

An MPS can only charge this if the resident's means assessment indicates they must pay an accommodation payment. The resident's means are determined via a pre-entry means assessment from Services Australia.

Fees and charges under the MPSP – Consumer fact sheet

14.2.6. Fees payable by older people receiving transition care

Registered providers may ask individuals to pay a care fee as a contribution to the cost of their care. Any fees must be fully explained to the individual and the amount charged forms part of the service agreement between the individual and registered provider.

The maximum amount that can be charged as per section 286-10 of the *Aged Care Rules 2025* is:

- if Transition Care Program (TCP) is delivered through the residential care service group —the amount obtained by rounding down to the nearest cent the amount equal to 85% of the basic age pension amount (worked out on a per day basis); or
- if TCP is delivered in a community/home setting and is delivered through the home support, or assistive technology service groups — the amount obtained by rounding down to the nearest cent the amount equal to 17.5% of the basic age pension amount (worked out on a per day basis).

An individual's access to transition care should not be affected by their ability to pay fees but should be decided based on their need for care and the capacity of the registered provider to meet that need. Decisions on whether to charge fees are entirely at the discretion of each State and Territory. The Australian Government recommends that fees be waived for financially disadvantaged individuals. Information on the cost of transition care for individuals is outlined on the My Aged Care website.

Transition care | My Aged Care

Transition Care Program Guidelines – November 2025 | Australian Government Department of Health, Disability and Ageing

14.2.7. Non-Australian residents

Non-Australian residents are not excluded from entitlements under the *Aged Care 2024* (the Act) and Visa holders do not require a Medicare Card in order to access an assessment.

Under the Act, non-Australian residents may be eligible for Government assistance with their aged care costs, if the person has been approved by an assessor and has had their income (for home care) or means (for residential care) assessed by Services Australia.

While the Australian Government is the majority funder of aged care, beyond this support it is expected that people will use their income and/or assets, depending on their care type, to contribute to the costs of their care, where they can afford to do so. The amount that the person can be asked to contribute will be assessed by Services Australia under the same rules as any other aged care recipient.

In the event that a non-Australian resident client requests advice from an assessor regarding what fees and payments they may be required to contribute towards their home care or residential care services, they should be advised to complete an income or means assessment to determine their contribution. This applies for all clients who wish to receive Government assistance with the cost of their care, regardless of residency status.

Income and means assessment

15. APPENDIX A – Glossary

Table 59. Glossary of terms

Term	Acronym/ abbreviation	Definition
Administrative Review Tribunal	ART	The Administrative Review Tribunal (ART) provides independent merit reviews of a wide range of administrative decisions made by the Australian Government. The ART can review decisions made under Commonwealth and Norfolk Island laws. The ART aim to make their review process accessible, fair, just, economical, informal and quick.
Aboriginal and Torres Strait Islander Aged Care Framework		This Framework establishes a 2035 vision for older Aboriginal and Torres Strait Islander people to age well by having their spiritual, physical and mental health needs met through holistic, high-quality and culturally safe aged care. This care should promote wellbeing, deliver trauma aware and healing informed responses and empower connection to culture, family, community and Country or Island Home.
Aged Care Act 2024 (Cth)	The Act	The *Aged Care Act 2024* (Cth) replaces the *Aged Care Act 1997* (Cth) as the primary piece of aged care legislation from 1 November 2025. In response to the first recommendation of the Royal Commission into Aged Care Quality and Safety, the Act was developed to implement fundamental reforms to aged care. It provides a legislative basis for a rights based aged care system focused on the safety, health and wellbeing of older people. The legislative framework provided by the Act sets out the governance of the aged care system and the requirements to access and deliver funded aged care services. It further introduces a new risk-based regulatory model focused on increasing provider accountability and encouraging the delivery of high quality funded aged care services by registered providers.
Aged Care (Consequential and Transitional		The *Aged Care (Consequential and Transitional Provisions) Act 2024* provides for transitional arrangements to support the commencement of the *Aged Care Act 2024*.

Term	Acronym/ abbreviation	Definition
Provisions) Act 2024		
Aged Care Act 1997 (Cth)		From 1 November 2025, the *Aged Care Act 1997* (Cth) will cease as the primary piece of aged care legislation. It will be superseded by the *Aged Care Act 2024* (Cth). From the cessation of the Act on 1 November 2025, Assessment Organisations should consult the *Aged Care Act 2024* (Cth) for information on access, delivery and governance of the aged care system.
Aged Care Assessment Quality Framework	Framework	Assessment organisations are required to use the Aged Care Assessment Quality Framework to maintain a consistent, high quality assessment experience for every older person.
Aged Care Diversity Framework		The Aged Care Diversity Framework is an overarching set of principles designed to ensure an accessible aged care system where people, regardless of their individual social, cultural, linguistic, religious, spiritual, psychological, medical and care needs are able to access respectful and inclusive aged care services.
Aged care needs assessor		A person who conducts aged care assessments, for home support and comprehensive assessments. An aged care needs assessor can be a clinical assessor or a non-clinical assessor.
Aged Care Principles		From 1 November 2025, the *Aged Care Act 2024* (Cth) will replace existing aged care legislation including the Aged Care Principles. Once commenced, Assessment Organisations should consult the *Aged Care Act 2024* (Cth) for information on access, delivery and governance of the aged care system.
AN-ACC Assessment Tool		Assessment tool used by residential aged care funding assessors to conduct residential aged care funding assessments.

Term	Acronym/ abbreviation	Definition
Assessment organisations	N/A	An entity engaged by the Department to provide Aged Care Needs Assessment Services and/or RAC Funding Assessment Services.
Assessor	N/A	An aged care needs assessor.
Aged Care Specialist Officer	ACSO	ACSO, located in some Services Australia service centres, help people with their aged care matters and provide in-depth support including in relation to financial information and means assessment.
Active, appointed decision maker	N/A	In policy, 'active, appointed decision maker' is the term used for a person who has active, decision-making authority for an older person under a Commonwealth, state or territory arrangement. This includes a person who would be considered a 'guardian etc.' under the *Aged Care Act 2024* (Cth). If a person is a registered supporter who relied on their authority as an active, appointed decision maker recognised under the Act for an older person to become registered (for example, the person is also an enduring attorney for the older person they are registered to support), they are recorded as a 'supporter guardian' for Information Communications Technology (ICT) purposes. Active, appointed decision makers can only make decisions for an older person within the scope of their legal authority under a Commonwealth, state or territory arrangement.
Assistive technology	AT	Is any item, piece of equipment or product that is used to help an older person do things more easily or complete activities they can no longer do independently.
Assistive Technology and Home Modifications (AT-HM) list	AT-HM list	A list that sets out the defined equipment, products, and home modifications that can be purchased for eligible participants under the AT-HM scheme.

Term	Acronym/ abbreviation	Definition
Assistive Technology and Home Modifications scheme	AT-HM scheme	The scheme provides assistive technology and home modifications funding for eligible participants.
AT-HM scheme guidelines		The AT-HM scheme guidelines provide additional information and processes in relation to the AT-HM scheme.
AT-HM tier guide		A guide created to support assessors in making an AT-HM funding tier recommendation.
Australian National Aged Care Classification	AN-ACC	Funding model for residential aged care, effective from 1 October 2022.
Australian Privacy Principle/s	APP/s	The Privacy Act includes 13 APPs in Schedule 1 that apply to the handling of personal information by most Australian and Norfolk Island Government agencies and some private sector organisations.
Care finder		Care finders assist vulnerable older Australians who do not have someone who is able to help them access aged care services and other relevant supports in the community. Contact information for care finder services in each region is on the My Aged Care website at Help from a care finder | My Aged Care
Classification		Refers to the classification of a Support at Home participant, including: • Ongoing classification (Classifications 1-8) • Short-term classifications (AT-HM scheme, Restorative Care Pathway Classification and End-of-Life Classification). Also refers to residential care classification (ongoing or short-term)

Term	Acronym/ abbreviation	Definition
Clinical aged care needs assessor		A clinically trained assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Commonwealth and in the My Aged Care Workforce Learning Strategy v 1.5 (or subsequent versions). A clinical assessor undertakes complex (comprehensive) aged care needs assessments with older people and will be required to exercise clinical judgement.
Clinical Assessment Delegate	Clinical Delegate	A Clinical Assessment Delegate is a position held by an employee of an assessment organisation who has delegation under the Act to approve an older person for all service groups, classification types and classification levels.
Commonwealth Continuity of Support Programme	CoS	The Continuity of Support Programme has been replaced with Disability Support for Older Australians (DSOA).
Commonwealth Home Support Program	CHSP	The Commonwealth Home Support Program provides a broad range of entry-level support services to assist older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people and people who are homeless or at risk of homelessness) to live independently in their homes and communities. From 1 November 2025, the CHSP comes under the *Aged Care Act 2024*.
Comprehensive assessment		An assessment type for people with more complex needs. Comprehensive assessments are undertaken by clinical assessors.
Cultural Safety for Aboriginal and Torres Strait Islander people		The National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC) defined cultural safety as: 'Cultural safety requires understanding one's own culture and the impact that your culture, thinking, and actions may have on the culture and wellbeing of others through ongoing critical self-reflection. Only the care recipient themselves can determine whether the service is culturally safe. Ensuring access to a culturally

Term	Acronym/ abbreviation	Definition
		safe, respectful, responsive and racism free aged care system is inherent for the optimal safety, autonomy, dignity, and absolute wellbeing of Aboriginal and Torres Strait Islander Elders, senior and older people, their families and community. Aged care service providers and workers must take responsibility for building trust and relationships with Aboriginal and Torres Strait Islander service users, and their families, and for creating a new aged care system which centres on their living experience, cultural, and ageing needs, as determined by Aboriginal and Torres Strait Islander service users themselves. The implementation of a trauma aware, healing informed approach to professional practice, and facilitating a greater understanding and respect for individual and collective cultures, histories, knowledges, traditions, stories, and values of Aboriginal and Torres Strait Islander service users, their families and communities, will greatly support the delivery of a quality and culturally safe aged care system. Aged care service providers must also firmly commit to continuously measure and improve structures and behaviours necessary for cultural safety and quality support to remain embedded in the Australian aged care system' According to the Australian Health Practitioner Regulation Agency (AHPRA): "Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities." It involves ongoing critical reflection by health practitioners on their own knowledge, skills, attitudes, and power differentials, and how these affect their practice
Departmental delegate		A departmental employee whose position has been delegated powers and functions under a section of the *Aged Care Act 2024* (Cth) by the System Governor.

Term	Acronym/ abbreviation	Definition
Disability Support for Older Australians	DSOA	DSOA provides funding for a range of services including Assistance in Supported Independent Living, Assistance with Self-Care Activities, Specialist/Behavioural Intervention Support, Therapy, and Case Management.
Elder Care Support Program		This workforce helps older Aboriginal and Torres Strait Islander people, their families and carers, to access aged care services across urban, regional and remote Australia to meet their physical and cultural needs.
Aboriginal and Torres Strait Islander Assessment Organisations	FNAO in My Aged Care System	Aboriginal and Torres Strait Islander Assessment Organisations were established from August 2025 to provide culturally safe, trauma aware and healing informed assessments.
Formal Services		Where formal services are referred to in this Manual these are paid services, such as government funded support.
Good Practice / Best Practice		Good practice is a matter of action. Best Practice is a recommendation.
Home modifications	HM	Changes to an older person's home to create a home environment that is safer and more accessible, so they can remain living safely at home.
Home Care Package Program	HCP	The HCP Program supported older Australians with complex care needs to live independently in their own homes. There were 4 levels of support — from level 1 for basic care needs to level 4 for high care needs. The Program ceased on 31 October 2025, replaced by the Support at Home program.
Informal Services		Where informal services are referred to in this Manual this is the unpaid support provided by carers, family, neighbours or other community organisations.

Term	Acronym/ abbreviation	Definition
Integrated Assessment Tool	IAT	The Integrated Assessment Tool (IAT) is the assessment tool used by assessors to conduct aged care needs assessments for older Australians who are seeking to access government subsidised aged care services. The IAT allows assessors to collect detailed and consistent information about the older person once and ensure service recommendations and referrals are tailored to their current needs.
ISBAR		The ISBAR framework represents a standardised approach to communication which can be used in any situation. It stands for Introduction, Situation, Background, Assessment and Recommendation. The ISBAR is the format which must be used when drafting a Support Plan.
Multi-Purpose Service Program	MPSP	The Multi-Purpose Service Program (MPSP) is a joint initiative of the Australian Government and state and territory governments. It aims to deliver flexible and integrated health and aged care services to some small rural and remote communities that could not viably support stand-alone hospitals or aged care facilities.
My Aged Care contact centre	The contact centre	The My Aged Care contact centre is the starting point to access Australian Government-funded aged care services. The Freecall phone line (1800 200 422) and website https://www.myagedcare.gov.au/contact-us can help older Australians, their families and carers to get the help and support they need.
My Aged Care service provider and assessor helpline	Helpline	My Aged Care service provider and assessor helpline (1800 836 799) is the industry helpline for My Aged Care portal issues. They provide a reference number to track the progress of a complaint or issue and notification when the ticket is closed. Issues can be escalated to other teams within the department as appropriate. Call from 8am to 8pm Monday to Friday or 10am to 2pm Saturday.

Term	Acronym/ abbreviation	Definition
My Aged Care Workforce Learning Strategy		The My Aged Care Workforce Learning Strategy v1.5 (Workforce Learning Strategy), and subsequent editions of this strategy defines and sets the minimum training requirement for the Single Assessment System workforce and the My Aged Care workforce, including timeframes for completion. The My Aged Care Assessment Workforce Learning Strategy can be found at this link.
My Aged Care Learning Management System	MAClearning	The delivery of training to the My Aged Care Workforce organisations occurs via the My Aged Care Learning Management System (MAClearning). MAClearning provides assessors with: • access to mandatory and optional online learning, • information about mandatory appraisal activities, and • a record of all completed learning and appraisals
My Health Record	MHR	My Health Record is a secure online summary of key patient health information. Healthcare providers can access the system to view and add information.
National Aboriginal and Torres Strait Islander Flexible Aged Care Program	NATSIFACP	The National Aboriginal and Torres Strait Islander Flexible Aged Care Program funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their family, country, island home and community. These services are mainly located in remote and very remote locations.
National Disability Insurance Scheme/Agency	NDIS or NDIA	The NDIS provides support for people with disability, their families and carers in Australia. The NDIS will provide all Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life. This may include personal care and support, access to the community, therapy services and essential equipment.

Term	Acronym/ abbreviation	Definition
Non-clinical aged care needs assessor	Non -clinical assessor	An assessor who meets the qualification and training requirements outlined in the assessment organisation's contractual agreement with the Commonwealth and in the My Aged Care Workforce Learning Strategy v1.5 (or subsequent versions). A non-clinical assessor undertakes simple (home support) aged care needs assessments with older people.
Non-clinical assessment delegate	Non-clinical delegate	A Non-clinical Assessment Delegate is a position held by an employee of an assessment organisation who has delegation under the Act to approve entry-level services arising from a home support assessment. They are restricted to approving access to the Commonwealth Home Support Program (CHSP).
Prescribed assistive technology		Assistive technology that would benefit from a prescription from a suitably qualified health professional.
Privacy Act 1988	The Privacy Act	The *Privacy Act 1988* applies to the collection, retention and use of personal information by assessors and regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information and access to and correction of that information.
Progressive condition		A medical condition that worsens over time, resulting in a range of limitations in function which can affect quality of life, daily living and community activities. (The 13 conditions listed below are all eligible AT-HM progressive conditions under SaH). These conditions include: • Cerebral Palsy • Epilepsy • Huntington's Disease • Motor Neurone Disease (MND) noting different phenotypes require different management • Multiple Sclerosis (MS) • Parkinson's Disease • Late effects of Polio • Spinal Cord Injury

Term	Acronym/ abbreviation	Definition
		• Spinal Muscular Atrophy • Stroke • Acquired Brain Injury noting different types of brain injury require different management • Muscular Dystrophies and Muscular Atrophies.
Reassessment		In this manual, the term 'reassessment' is used to describe a subsequent assessment of a person's aged care needs who is already accessing aged care services. Section 64 of the *Aged Care Act 2024* provides for aged care needs reassessments. A reassessment may be required when an individual's circumstances have changed. In the *Aged Care Act 2024* the term 'reassessment' is used as an umbrella term to describe both SPRs and reassessments. An individual may request a reassessment if they believe their aged care needs have changed, or it may be identified through a scheduled SPR.
Reablement		Wellness and reablement are related concepts, often used together to describe an overall approach to service delivery. Wellness and reablement approaches are based on the idea that, even with frailty, chronical illness or disability, most people want and are able to improve their physical, social, and emotional wellbeing, to live autonomously and as independently as possible. Reablement offers time-limited interventions and emphasises assisting people to maintain, regain, improve confidence and functional capacity and maximise independence and autonomy. It focuses on specific goals and seeks to enable people to live their lives to the fullest.
Residential aged care funding assessment	RAC funding assessment	An assessment a residential aged care funding assessor completes using the AN-ACC assessment tool. Defunct term: AN-ACC assessment.

Term	Acronym/ abbreviation	Definition
Residential aged care funding assessor	RAC funding assessor	An aged care assessor who is completing a residential aged care funding assessment using the AN-ACC assessment tool. Defunct term: AN-ACC assessor.
Residential Care (ongoing)		Residential care is permanent ongoing care provided in an aged care home. Residential care is designed to assist people assessed as being no longer able to care for themselves within their home or community settings.
Residential Respite Care (Residential Care – short term)		Residential respite care is short-term care provided in an aged care home. It can be on a planned or emergency basis. Respite gives a carer or care recipient a break from their usual care arrangements. A clinical assessor assesses, and a clinical delegate approves care recipients to access respite care.
Restorative Care Pathway	RCP	The Restorative Care Pathway, under Support at Home, has replaced the Short-Term Restorative Care (STRC) programme. It aims to provide early intervention opportunities to support older people to restore function through coordinated, goal orientated support focusing on multi-disciplinary allied health services. It can be delivered in home or community settings and can be for up to 16 weeks.
Referral Codes Letter		The referral codes letter is also known as the 'Referral codes and List of Providers' Letter. On the assessor portal, it is generated via the 'Generate Referral code Letter' button.
Single Assessment System program		The Commonwealth Government funds assessment organisations to administer aged care needs assessments, which include both home support and comprehensive assessments. This term is used to define the assessment program which includes all assessment types.
Single Assessment System workforce		Refers to the aged care assessment workforce from late 2024. This term also includes First Nations Assessment Organisations and

Term	Acronym/ abbreviation	Definition
		organisations that deliver Residential Aged Care Funding assessments.
Specialist Aged Care Programs		Refers to a Government program for delivering funded aged care services that (a) is given effect through one or more agreements or arrangements entered into by the Commonwealth under subsection 247(1) or section 264 of the Act for the program; and (b) meets any other requirements prescribed by the rules. It includes the Multi-Purpose Service Program, Transition Care Program, National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) , and Commonwealth Home Support Program (CHSP).
Specified need		Refers to participants who require ongoing assistive technology funding for the essential maintenance of their assistance dog.
(Commonwealth) Subsidised and non-subsidised aged care services		Commonwealth subsidised aged care programs broadly include those under the *Aged Care Act 2024.* These services can receive My Aged Care portal referrals and can be service recommendations on the Support Plan. Non-subsidised services are those services and supports that are NOT Commonwealth funded aged care. These services cannot receive referrals through the My Aged Care portal, are NOT listed in the My Aged Care service finder and are noted as general recommendations on the Support Plan.
Support at Home program	SaH	Support at Home is a home care program that helps older people remain at home as they age by delivering coordinated care and services to meet their assessed ageing related care needs.
Support Plan		The Support Plan is an important and ongoing document for the older person that can be updated as an older person's needs change. It details the outcomes of discussions with, and assessments of, the older person, including what the older person would like to improve and achieve (their goals), and agreed actions to be

Term	Acronym/ abbreviation	Definition
		taken. It is a continuous document (i.e. an older person only has one Support Plan).
Support plan review	SPR	A support plan review relates to the effectiveness and appropriateness of the older person's Support Plan. An assessor may set a review date on the Support Plan at the time of the assessment or initiated on an ad-hoc basis. A review may also be requested by an older person or a service provider where there is a change in the older person's needs or circumstances. It may be completed over-the-phone with the older person.
Transition Care Program	TCP	Transition Care provides short-term, goal oriented and therapy-focused care for older Australians after hospital stays either in a home or community setting or in a residential aged care setting.
Triage Delegate		A Triage Delegate is a position held by an employee of an assessment organisation who has delegation under the Act to make decisions about an older person's access to assessment. They determine whether an individual is eligible for a needs assessment and whether a change in circumstances requires a reassessment of their needs.

16. APPENDIX B – Contact details

Table 60. Contact details

Contact point	Details
Right of Review	A person can request a review to an assessment outcome by writing to: By Email: agedcarereviews@health.gov.au By Post: The System Governor Department of Health, Disability and Ageing Attn: Review of Decisions Section GPO Box 9848 ADELAIDE SA 5001
Assessment Operational Manager	Please contact your assessment organisation operational manager in the first instance for all queries and/or issues.
Registered supporters	Documentation to request to register a supporter can be sent to My Aged Care by: • Uploading to the My Aged Care Online Account. • Uploading it as part of the online registration process on the My Aged Care website. • Sending a digital copy via the My Aged Care online form available at: https://www.healthdirect.gov.au/myagedcareupload or • Providing it to an Aged Care Specialist Officer or assessor for face-to-face help uploading it to My Aged Care. • Posting to: My Aged Care PO Box 1237 Runaway Bay, QLD 4216
Carer Gateway	1800 422 737
My Aged Care contact centre	1800 200 422
My Aged Care Service Provider and Assessor Helpline	1800 836 799 8am to 8pm Monday to Friday or 10am to 2pm Saturday
My Aged Care complaints	A person can make a complaint by:

Contact point	Details
	• calling My Aged Care on 1800 200 422 • posting their complaint to: My Aged Care Complaints PO Box 1237 Runaway Bay QLD 4216 • If you are not satisfied with the response you receive, send an email with the details of your complaint and reference number to myagedcaresupport@health.gov.au. • For more information visit: Making a complaint | My Aged Care
Services Australia	1800 227 475 (Aged Care Line - consumers)

17. APPENDIX C – Clinical governance guidance for aged care needs assessment organisations

Guidance purpose

This guidance aims to help aged care assessment organisations to meet their responsibilities for ensuring the quality of needs assessments, through the implementation of effective clinical governance. The sections below are for people within an assessment organisation responsible for developing their clinical governance framework. It describes the importance of good clinical governance, details the elements of an effective clinical governance framework in an aged care needs assessment context and outlines the minimum supports that must be in place to support clinical and non-clinical staff.

This guidance should be considered in conjunction with the resources on clinical governance in the provision of aged care services available on the Aged Care Quality and Safety Commission's website.

What is a clinical governance framework and why is it important for aged care assessment organisations?

Clinical governance is an integrated system of organisational behaviours, policies, procedures, responsibilities, and quality assurance mechanisms that support consistent and high-quality care in organisations across the health, aged care and many social services sectors. A clinical governance framework is a framework that describes an organisation's approach to clinical governance.

Your assessment organisation's clinical governance framework must describe the practical, clinical supports that are in place for staff who may need to exercise clinical judgement or undertake elements of an aged care needs assessment that are clinical in nature.

Good clinical governance supports everyone in your assessment organisation to achieve high quality aged care assessments that deliver accurate and appropriate outcomes for all older people. High quality assessments are defined in the Aged Care Assessment Quality Framework as:

Personal: an assessment is a respectful conversation and is responsive to an older person's individual situation, context, goals and aspirations.

Effective: assessments are undertaken in depth and to completion, ensuring an older person's needs are fully identified and an older person can exercise choice and control in accessing the right services appropriate for them (as available and as eligible).

Connected: the older person understands how and why the assessment process connects to their aged care journey.

Safe: the older person is provided a physically, emotionally and culturally safe assessment where their unique experiences are respected and factored into the way they are assessed for aged care. All assessments are delivered in a safe environment and free from harm.

Importantly, clinical governance must be embedded in your organisational culture. Leaders must foster a culture that supports and promotes consistent, high quality assessments and integrates clinical governance into the broader organisational governance. Your organisation's governing body is accountable for ensuring adequate clinical support is in place for staff, understanding the risks associated with undertaking assessments, monitoring performance, and continuously driving improvement.

How to use this guidance

This guidance outlines the elements that your assessment organisation must include in its clinical governance framework, and details the minimum, practical clinical supports that must be in place for your workforce who may need to exercise clinical judgement or undertake an assessment that is clinical in nature.

Your assessment organisation may develop its clinical governance framework in a format that suits them and include additional elements that are not covered in this guidance. For assessment organisations with an existing clinical governance framework, a review will be required to ensure all elements in this guidance are included.

Elements of a clinical governance framework

At a minimum your assessment organisation's clinical governance framework must demonstrate how it will:

Define **roles and responsibilities** to provide clarity on how clinical governance will operate.

Recruit, **train and accredit staff** to build a highly skilled and qualified assessor workforce.

- Provide **clinical support** to assessors.
- Monitor assessment quality and drive continuous improvement.
- Build relationships to foster innovation and continuous improvement.

The minimum clinical support requirements that sit under each of these elements are detailed in the next section.

Element 1: Define roles and responsibilities to provide clarity on how clinical governance will operate

Table 61. Roles and responsibilities

Clinical support requirement	Implementation
Staff understand the boundaries of their role as a clinical assessor or clinical delegate, and the functions that are not suitable to perform when undertaking those roles. E.g. Clinical assessors who are registered nurses should not dress wounds when undertaking an assessment.	Each staff member is assigned the correct clinical role/s in the My Aged Care Assessor Portal and job position on MAClearning. The organisation's Work, Health and Safety framework outlines procedures that uphold staff safety. Completion of workplace training on the organisation's clinical attendance policy and clinical governance framework.
Staff understand the boundaries of their role as a non-clinical assessor and non-clinical	Completion of workplace training on the organisation's clinical attendance policy and clinical governance framework.

Clinical support requirement	Implementation
assessment delegate and understand when and how they will need to operate under their organisation's clinical governance throughout the assessment process.	

Element 2: Recruit, train and accredit staff to build a highly skilled and qualified assessor workforce

Table 62. Role and training requirements

Clinical support requirement	Implementation
Every assessor has capability to perform a needs assessment, prior to undertaking an assessment with an older person.	Completion of induction training outlined in the My Aged Care Workforce Learning Strategy v1.5 (and subsequent versions) including mandatory online learning on the MAClearning system and completion of appraisal activities to validate assessor capabilities.
Prior to a clinical assessment delegate approving their first service recommendation, the delegate is competent to approve service recommendations.	Completion of induction and delegate training outlined in the My Aged Care Workforce Learning Strategy v1.5 (and subsequent versions) and mandatory online learning on the MAClearning system.
Prior to a triage delegate triaging their first assessment referral, the delegate is competent to undertake triage.	Completion of induction and delegate training outlined in the My Aged Care Workforce Learning Strategy v1.5 (and subsequent versions) and mandatory online learning on the MAClearning system
All non-clinical assessors are competent in seeking clinical attendance in the event they trigger clinical questions in the IAT.	Completion of workplace training on the organisation's clinical attendance policy and clinical governance framework.
Relevant staff are qualified to undertake a clinical role.	Staff who are recruited to clinical roles within the assessment organisation meet the qualification requirements outlined in the assessment organisation's contractual agreement and training requirements detailed in the My Aged Care Workforce Learning Strategy v1.5 (or subsequent versions).

Element 3: Provide clinical support to assessors

Table 63. Clinical support to assessors

Clinical support requirement	Implementation
Provide ongoing support for assessors in the field	Provide ongoing clinical governance support for assessors in the field including providing peer support

	and advice on emerging and specific issues as well as providing supervision to non-clinical staff during the clinical attendance process and in finalising support plans. Ongoing support is provided through various communication channels via the assessment organisation's standard operating procedures.

Element 4: Monitor assessment quality and drive continuous improvement

Table 64. Monitoring of assessment quality and continuous improvement

Clinical support requirement	Implementation
Clinical staff are supervised and mentored by a clinically trained Team Leader	Team leaders regularly engage with triage delegates, assessment delegates and assessors in peer review processes
Staff receive regular feedback about the quality of their assessments and the performance of their organisation	Assessment organisations measure and report the extent to which it achieves the Aged Care Quality Standards, and quality goals included in the Aged Care Assessment Quality Framework. The Assessment organisation's leadership team use quality assurance data to drive continuous improvement in clinical governance policies and processes. The Assessment organisation actively participates in any external evaluation or quality assurance processes.

Element 5: Build relationships to foster innovation and continuous improvement

Table 65. Relationship building to foster innovation and continuous improvement

Clinical support requirement	Implementation
Build effective working relationships with local support services	Implement systems and processes to ensure positive communication between service and care providers within the aged and health care systems.
Foster an organisational culture of regular and effective communication that addresses risks and issues and promotes continuous improvement	Assessment organisations hold regular team meetings/teleconferences to address issues arising, share experiences and clinical expertise (including case study discussions)
Assessment Organisation's representatives participate in relevant forums organised by the Department	Assessment organisations must send representatives in person to attend forums for assessment organisations as organised by the Department.

18. APPENDIX D – Clinical attendance

Questions in the IAT that require clinical attendance

Table 66. IAT questions that require clinical attendance

IAT clinical questions	When these questions will be triggered	Detail
Advanced Medical Assessment section	Answers 'Moderately' or 'Quite a bit' to Q *Impact of health issues on normal activities.*	This question set identifies whether the older person has had recent contact with a GP and/or has regular health checks, has been admitted to hospital in the past 12 months and whether the older person has and/or has had allergies and/or sensitivities such as food, medication and environmental allergies and/or sensitivities. See IAT User Guide: Integrated Assessment Tool user guide (health.gov.au)
Urinary incontinence and Revised Urinary Incontinence Scale (RUIS)	Answers No to '*Is the older person managing urinary incontinence issue?*'	An assessor should use the RUIS to assess urinary incontinence. Urinary incontinence refers to the involuntary loss of bladder control. The severity can vary, including occasional leakage of urine when coughing or sneezing. It would become an issue at the more severe end when an older person often experiences a sudden and strong urge to urinate (urgency) that doesn't allow enough time to reach a toilet. Continence is a sensitive and private issue. The assessor must use clinical judgement to determine the appropriateness of administering the RFIS with the older person at assessment. Urinary incontinence | healthdirect

IAT clinical questions	When these questions will be triggered	Detail
Bowel incontinence and Revised Faecal Incontinence Scale (RFIS)	Answers 'No' to '*Is the older person managing bowel incontinence issue?*.'	(PDF) Technical Manual and Instructions: Revised Incontinence and Patient Satisfaction Tools, Version 2 (researchgate.net) (tool on pg. 27) Technical Manual and Instructions for Revised Incontinence and Patient Satisfaction Tools 1 (anzctr.org.au) An assessor should use the RFIS is used to assess faecal incontinence. Continence is a sensitive and private issue. The assessor must use clinical judgement to determine the appropriateness of administering the RFIS with the older person at assessment.
GPCog- Step 2 and extended cognitive assessment	If the older person has answered any of the Qs in GPCog- Step 1 incorrectly.	The GPCog- step 2 and extended cognitive assessment is a screening tool for cognitive impairment. It builds on the questions asked in GPCog- step 1. GPCOG | Home The GPCOG: A New Screening Test for Dementia Designed for General Practice (Step 2 Qs at bottom of the journal article)
Extended Behaviour Assessment	Answers YES to the question. *Are there any reported changes in the older person's personality?*	This question set identifies changes in an older person's behaviour across several behavioural types. See IAT User Guide: Integrated Assessment Tool user guide (health.gov.au)

IAT clinical questions	When these questions will be triggered	Detail
Advanced Psychological Assessment (PHQ-4)	If there is a total score of three or more from the first two PHQ questions (Feeling nervous, anxious or on edge AND not being able to stop or control worrying), additional questions on advanced psychological assessment will be prompted.	This question set identifies the extent to which an older person experiences psychological distress. See IAT User Guide: Integrated Assessment Tool user guide (health.gov.au)
Geriatric Depression Scale (GDS)	Additional question in advanced psychological assessment. Answer 'yes' to *Do you want to complete the Geriatric Depression Scale?*	The GDS is a basic screening measure for depression in older people. Geriatric Depression Scale (stanford.edu)

Older person scenarios — clinical attendance

Meet Clyde

Clyde is 78 years old and needs some extra support so that he can continue to live in his home. He applies for an aged care assessment through My Aged Care. When Clyde is contacted by the assessment organisation, he is asked some preliminary questions (known as triage) before his assessment is scheduled. Clyde has heard some bad stories recently about residential aged care and he is worried that the assessment will result in him moving into an aged care home. Clyde feels nervous when answering the questions at triage and he doesn't fully disclose his health concerns during the conversation.

Clyde is triaged for a home support assessment. A non-clinical assessor is assigned to undertake the assessment, and travels to Clyde's home. During his assessment, Clyde's answers trigger questions that require clinical judgement. The assessor explains to Clyde that there are some questions that will need to be asked with a clinical assessor, who they can call on their tablet.

Clyde agrees and a clinical assessor is video called. Clyde and his assessor explain his situation to the clinical assessor, and the IAT questions that have been triggered. Together, the assessors undertake the whole assessment and record Clyde's needs in the IAT. When the non-clinical assessor gets back to the office, they finalise the assessment, consulting with the clinical assessor to make the recommendations.

Clyde is found eligible for services. The assessor converts the assessment to a comprehensive assessment at the end of the assessment. Clyde's assessment is finalised and is sent to an assessment delegate for approval.

Meet Jane

Jane is 70 years old and lives alone. Jane and her family have spoken about her needing some support to help with home duties. Jane has chronic arthritis and sometimes this can affect her activities. At the time she first speaks to an assessment organisation about her health and abilities (triage), the weather is warm, and Jane is feeling good. Her arthritis is not affecting her day-to-day activities.

Jane is triaged for a home support assessment. A non-clinical assessor is assigned to undertake the assessment, and travels to Jane's home. On the day of the assessment, the weather is cold, and Jane isn't feeling as well as she did at triage. During her assessment, Jane answers a question which triggers a question set that requires clinical judgement. The assessor knows that a clinical assessor is not available to be in attendance during the assessment. The assessor selects 'no' to the declaration and makes a note of the questions that are triggered. The assessor explains that they can only ask certain questions in the assessment today and that some questions will need to be asked with a clinical assessor at a later time. The assessor asks the questions that do not require clinical judgment. The assessment concludes. When the assessor gets back to the office, the assessor speaks to their Team Leader or a clinical assessor about the assessment. At this stage it is determined that the clinical assessor can complete the clinical questions by calling Jane and asking the questions raised during the assessment. The original, non-clinical assessor arranges a time to contact Jane with the clinical assessor to ask the remaining questions. Together they finalise the assessment and although the clinical questions were triggered during the assessment, it is found that Jane's needs can be supported through CHSP services

Meet Alex

Alex loves working with older people and is excited about their new role as a non-clinical aged care needs assessor. Alex arrives at the house of an older person to undertake a home support assessment. Alex is welcomed inside, and notes straight away that the older person's needs seem more complex than what was recorded at triage. Not long into the assessment, a clinical question is triggered that requires clinical judgement. Alex explains to the older person that there are some questions that they will need to ask with the support from a clinical assessor who they can call on Alex's phone. The older person agrees and a clinical assessor is called. Alex explains the situation, including the clinical questions that have been triggered. The clinical assessor considers the questions that have been triggered, Alex's experience as an assessor and the older person's situation. Based on these factors, the clinical assessor advises that it would be best for a clinical assessor to undertake the whole assessment.

Alex concludes the assessment and the older person's assessment is reassigned to a clinical assessor with high priority which occurs on another day.

19. APPENDIX E – Wellness and reablement

Introduction

My Aged Care has been established to support older people to maximise their independence and enable them to remain living safely in their own homes and communities. The role of the assessor is to work with the older person to develop an individualised Support Plan so the older person can focus on their own strengths and goals to better support their continued independence. This means assessors should not refer the older person for services they can do safely for themselves. The longer an older person avoids reliance on ongoing services, the longer they are likely to maintain their functional independence, giving them more good days doing the things that matter to them most.

Wellness and reablement approaches build on people's strengths and goals to promote greater independence and autonomy, and it starts with the assessment. Wellness and reablement are inclusive approaches that involve assessment, planning and delivery of supports that build on the strengths, capacity, and goals of individuals irrespective of age, capacity, diagnosis or setting. Referring for support that focuses on the individual's goals and recognises the importance of older people's participation is fundamental to aged care.

What is Wellness and reablement?

Wellness and reablement are related concepts, often used together to describe an overall approach to service delivery. They are grounded in the principle that older people, including those with frailty, chronic illness or disability, can maintain or improve their independence, and physical, social and emotional functioning. These approaches support older people to live with purpose, make autonomous choices, and participate in meaningful activities which supports their wellbeing.

By focusing on capacity-building and restoring or maintaining function, wellness and reablement approaches directly contribute to the wellbeing outcomes described in the Aged Care Act and Strengthened Aged Care Quality Standards. These support older people to live safely, independently, and with a sustained sense of meaning and connection in their own homes and communities.

Wellness

Wellness is a philosophy that informs how providers should work with participants by building on their strengths, abilities and goals to promote greater independence and quality of life. A wellness approach avoids 'doing for' when 'doing with' can support a participant to undertake an activity with less assistance, acknowledging the abilities of the participant and building on their strengths and skills. A wellness approach also aims to empower participants to take charge of, and participate in, informed decision-making about the care and services they receive. It's about listening to what the participant wants to do, looking at what they can do, and focusing on regaining or retaining their level of function so that they can continue to manage their day-to-day life.

Reablement

Reablement offers time-limited interventions that focus on achieving a participant's specific goal or desired outcome. It involves maintaining or regaining skills, improving functional capacity, improving confidence and enhancing capability so a participant can resume everyday activities. Reablement services apply a wellness approach and aim to get a client 'back on their feet,' and able to resume previous activities either without needing ongoing service delivery or with a reduced need for services. Service providers should identify opportunities for reablement as part of their ongoing support of participants.

Why wellness and reablement is important

Emerging research has demonstrated the benefits of focussing on older people's independence. Traditional models of service delivery that focus on what an older person can't do rather than what they can, leads to an over-reliance on services by older people, which has been linked with accelerated functional decline.

Understanding the ageing journey – the life curve

Research suggests the largest influencer in age-related decline is not genetics, but rather lifestyle choices. People who continue to do things for themselves tend to remain independent and live better, longer.

Professor Peter Gore of the Institute of Aging at Newcastle University in the United Kingdom has developed a framework to understand the age-related decline. The framework, called the LifeCurve™, looks at the impact of maintaining independence on quality of life and the rate of age-related functional decline. It illustrates that the sooner someone stops performing certain tasks for themselves, the faster they tend to lose their functional ability. The aim is to assist people to perform these daily tasks independently for as long as possible, to maximise independence and autonomy. Retaining physical ability helps people to continue doing the things they enjoy for longer.

The LifeCurve™ is shown at Figure 12. The vertical axis lists activities of daily living that older people generally lose over time, in the order in which they tend to be lost, from top to bottom, with the horizontal axis representing elapsed time. The timeframe for this decline is variable and can be influenced by behaviour and interventions. For example, difficulty cutting one's toenails is typically seen as an early indicator that intervention may be needed. The graph shows two trajectories: a sub-optimal life curve with a fast early decline; and an optimal life curve in which the early decline is slowed down to give people more good days before losing the ability to undertake activities like walking, shopping and personal care.

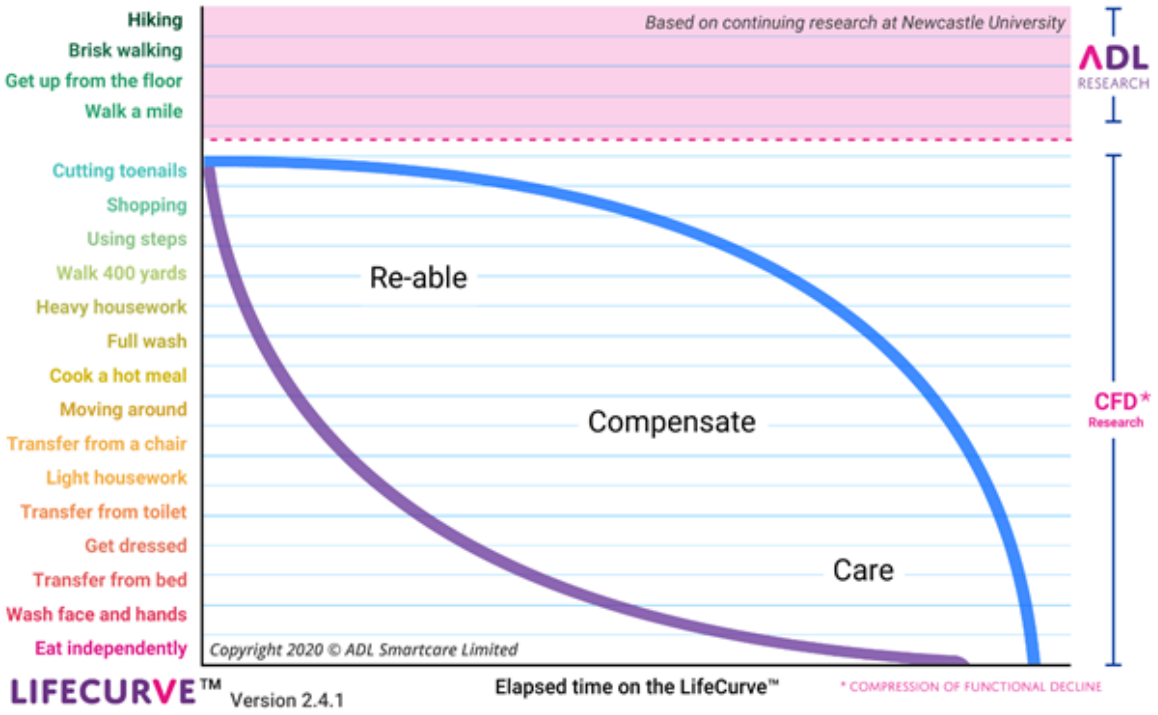


Figure 12 – LifeCurve™

The LiveUp website enables Australians over 65 years of age to check their health and find personalised suggestions for products and services that promote healthy ageing. LiveUp can suggest low-cost assistive products and equipment to help people with everyday living, as well as personalised exercises and services, to help them or a loved one with age-related wellbeing.

At the LiveUp website anyone can download the free LifeCurve™ that can track a person's health, giving them easy to understand long term advice tailored to their needs. To learn more about LiveUp, go to www.liveup.org.au or call 1800 951 971.

Benefits of a wellness and reablement approach

Older people are not the only ones who benefit from wellness and reablement. Evidence suggests there are also significant benefits to assessment organisations, service providers, families and carers, and the broader community.

Benefits for older people

Implementing a wellness and reablement approach at the earliest opportunity (with a focus on older person goals to maintain or regain functional capacity and social connectedness) can have significant long-term benefits for older people including:

- older people appreciate being asked what is important to them, and to be included in decision-making
- improved sense of purpose, autonomy and self-worth
- improved physical and emotional health and wellbeing
- reduction in service delivery needs

- increased ability to remain living independently and safely in their own homes for longer
- greater quality of life and retention of pride and dignity
- improved connection with community; and
- reduced strain on family and carer relationships.

Benefits for aged care assessment organisations

Reablement focused assessment has flow on benefits for aged care organisations as they can better utilise support workers to focus on more complicated tasks that their older people can't perform for themselves, resulting in more meaningful and fulfilling work. Importantly, it enables providers to broaden their older person base by offering more short-term support by freeing up longer term service provision. All of which better aligns to aged care reform initiatives and improving the ability to assessment and provider organisations to respond to changes in aged care policy.

Implementing wellness and reablement provides significant benefits for assessors and their older people including:

- reablement focussed (active) assessment better demonstrates need. This benefit extends to older people with poor reablement prospects, as active assessment better identifies if ongoing services are needed, or if short-term reablement support will help the older person get back to previous levels of independence
- reablement focussed assessment provides a more holistic approach to assessment
- greater job satisfaction by actively helping older people to identify goals and become more independent; and
- improved business reputation based on providing person-centred, holistic assessments that focus on individual older person goals, needs and preferences.

Benefits for families and carers

Wellness and reablement approaches can have significant benefits for family members and carers, including:

- opportunities to be involved in supporting their loved one to meet their goals
- peace of mind in knowing their loved one is retaining or regaining their independence, improving their wellbeing and quality of life
- reduced worry and concern over their loved ones along with reduced strain and pressure due to a decrease in caring requirements.

Older person scenarios — Applying a wellness and reablement approach

HARRY is a 70-year-old man who lives alone. After contacting My Aged Care, a face-to-face home support assessment was undertaken which identified Harry needed some assistance with clothes-washing and meals. The assessor applied a wellness and reablement approach in the assessment, asking Harry to show how he performed tasks around the home, observing what he could do for himself and asking him what goals he wanted to achieve.

At first, Harry didn't know what to say. He thought he was too old to set new goals but indicated he was open to doing the cooking. Harry said he lacked confidence and skills as his wife, who recently passed away, had always done most of the cooking. With this information, the assessor referred Harry for support with planning his grocery shopping and meal preparation. With this support, Harry could work out what he wanted to cook, plan his shopping to obtain the necessary ingredients, and then helped his support worker prepare the meals while receiving basic cooking instructions.

Learning these skills built Harry's confidence to manage his shopping and cook his own meals, increasing his independence and quality of life.

During the assessment, the assessor also encouraged Harry by helping him identify task simplification strategies to do the laundry with some support. Instead of referring for domestic assistance three times a week, the assessor advised Harry to wash and hang his clothes using a trolley and an easy-to-reach drying rack inside, instead referring him for once-a-week support to help him hang out heavier washing, like sheets and towels.

ELSA is a 72-year woman with osteoarthritis who has been receiving domestic assistance under the CHSP for two hours a week to provide assistance with general housework and laundry. Elsa required no other assistance.

During a support plan review, the non-clinical assessor applied a wellness and reablement approach to Elsa's continuing needs, asking Elsa to demonstrate how she completed light household chores such as dusting, wiping over surfaces, washing the dishes and using a lightweight carpet sweeper.

Applying a reablement approach, over a two-month period instead of 'doing for,' Elsa was encouraged to undertake some of these tasks by herself, whilst the support worker completed more difficult tasks, such as vacuuming and mopping.

Elsa still requires ongoing support; however, she is now more involved and independent, has increased activity levels, and feels more satisfied about continuing to live at home.

Principles of wellness and reablement

Wellness and reablement describe an overall approach to service delivery.

Employment of wellness and reablement approaches in aged care organisations promotes client wellbeing, independence, function, and management of activities of daily living.

In line with the Statement of Rights, ways to apply wellness and reablement approaches include:

- **Promote independence** – people value their independence, loss of independence can have a devastating effect, particularly for older people who may find it more difficult to regain.
- **Identify older person's goals and motivation** – a person's independence requires more than just services to help them remain in their home and maintain their current capacity. Service delivery should focus on supporting the older person to actively work towards their goals and improved independence wherever possible.
- **Consider physical and psychosocial needs** – independence is not limited to physical function, it includes both social and psychological function. Support should be tailored to the individual and aim to improve their physical, social and emotional wellbeing.
- **Encourage participation of older people** – being an active participant, rather than a passive recipient of services, is an important of being physically and emotionally healthy. Service delivery should focus on assisting a person to complete tasks, not taking over tasks that a person can do for themselves.
- **Regular assessment** – older person assessment should be ongoing, not one-off. It should focus on progress towards older person goals and consider the support and duration of services required to meet these goals.
- **Focus on strengths** - the focus should be on what a person can do, rather than what they can't. Wherever possible, services should aim to retain, regain, or learn skills rather than creating dependencies.
- **Support older people to reach their potential** – help older people to maintain and extend their activities in line with their capabilities.
- **Individualise support** – service delivery should be individualised and suited to the goals, aspirations and needs of the individual.
- **Regular review –** a person's assessment should be ongoing, not one-off. It should focus on progress towards goals and consider the support and duration of services required to meet these goals.

HELEN is a 78-year woman with osteoarthritis. Lately, Helen has had difficulty performing household cleaning duties and doing her laundry. At assessment, the assessor undertook a reablement-focused (active) assessment to better identify Helen's needs.

By asking Helen to show the assessor how she did her housework (active assessment), the assessor identified lighter tasks that Helen could still complete, but certain tasks impacted her arthritis. During the assessment, the assessor asked Helen what she enjoys and the goals she would like to achieve. Helen identifies she used to enjoy keeping her home clean and tidy but is feeling lonely because she worries visitors may think she isn't coping around the house as well as she used to.

In working with Helen to develop a Support Plan, the assessor focusses on Helen's strengths and the things she wants to regain/maintain. As a result of the active assessment, the Support Plan refers Helen for short-term reablement support over a two-month period where Helen does lighter housework while the support worker completes tasks that provoke Helen's arthritis, such as vacuuming and mopping.

Although Helen requires ongoing support with more difficult domestic duties, she has improved her functional capacity and feels more like herself. By adopting a strength-based approach to assessment and service delivery, focusing on 'doing with' not 'doing for,' Helen is able to maintain some physical activity and by regaining some independence she is feeling more fulfilled and capable. Helen has begun engaging with her friends again which has improved her social connectedness.

Time-limited support

Wellness and reablement approaches often involve time-limited services. Time-limited care aims to address an older person's specific barriers to independence and support them getting back to doing things for themselves. This involves a targeted timeframe, developed with the older person, for achieving their goals.

Understanding what a good day looks like for an older person and how it relates to their individual goals and outcomes is important for determining short-term support needs. This could be maintaining a level of activity or independence or working towards regaining it. Time-limited reablement services tend to be delivered within a 12-week period with the aim to wrap up services when the older person has met their goal or specific outcome. Time-limited reablement under the CHSP can be delivered by all service types (with the exception of Sector Support and Development).

Time-limited reablement may involve restorative care services where the client has the potential to make a functional gain.

Other time-limited support could include:

- training in a new skill or actively working to regain or maintain an existing skill

- modification to a person's home environment; or
- having access to assistive technology.

Wellness and reablement obligations and supports

As part of applying a wellness and reablement approach assessment organisations should:

- ensure that assessment referrals are targeted towards assisting older people to achieve their agreed realistic goals as outlined in the Support Plan
- apply a 'doing with' instead of 'doing for' approach where possible, offer time limited interventions
- monitor changes in older person's needs and regularly review Support Plans
- comply with wellness and reablement reporting requirements; and
- have an implementation plan outlining their organisation's approach to embedding wellness and reablement.

The department has developed online resources to help service providers embed wellness and reablement approaches into their practices and service delivery.

Other resources



Wellness and reablement resources page

Living well at home: CHSP Good Practice Guide provides practical guidance in how to adopt a wellness and reablement approach into service delivery.

Older person scenario – Supporting greater independence[10]

ADELINA is a 77-year-old woman who had a stroke which affected her left side. Her speech was unaffected, but her movement was restricted. She has little function in her left arm - her left leg is slightly affected, requiring her to walk with the assistance of a stick.

Adelina felt that she was unable to do very much for herself. She really wanted to be able to make her own cup of tea, however because of the lack of function in her left arm she felt she was dependent on carers and unable to make a cup of tea between carer visits unless a friend or neighbour came by. Adelina had become resigned that this was how her life would be. She was dispirited and resistant to her son's suggestion that she might do a bit more for herself.

However, at the request of her son, Adelina's Support Plan was reviewed by the assessor who recommended a referral to an occupational therapist. An occupational therapist was engaged under the CHSP who suggested she could be assisted to learn to use the microwave oven, and a kettle fitted onto a tipper so she could make her own tea.

For a number of weeks, Adelina was supported to build up her confidence in her ability to use the microwave and the kettle. After a few months Adelina was able to make meals for herself, her own cup of tea and is living a more independent life. As a result, Adelina said she is feeling more hopeful and has started to invite friends over for a meal.

[10] Wellness Approach to Community Home Care Information Booklet July 2008 produced by the Western Australian Department of Health

Cont. Adelina's son has been delighted to see his mother's renewed sense of self and independence.

Strategies to assist embedding wellness and reablement

Experience of organisations that have successfully embedded a wellness and reablement approach suggests that there are a number of key drivers for success. These include:

- a whole-of-organisation approach, including commitment from both management and staff
- reflecting wellness and reablement in organisational policy and procedures, especially in recruitment, employment, orientation, induction practices, position descriptions, and performance reviews.
- providing and encouraging staff training and education program
- changing the mindset for management, staff, volunteers, older people and their families and carers
- taking time to work with staff to ensure they understand the benefits and reasons for applying wellness and reablement approaches.
- understanding your organisation's maturity and readiness in terms of wellness and reablement is the first step to embedding the change; and
- ensuring communication materials need to reflect the wellness and reablement approach to assist with setting older person and staff expectations.

Older person scenarios — short-term wellness and reablement, and restorative interventions

DAVID is an 81-year-old man who was referred to My Aged Care following a fall he had two weeks prior. Although he sustained no specific injuries, David was quite shaken following the fall and now lacked confidence to shower himself independently.

David was referred for an assessment which identified that David was previously independent and was motivated to regain autonomy. The assessor also identified that David was still independent in many daily activities but was struggling with his personal care.

Based on the assessment, a Support Plan was developed with David which identified his goal of being able to maintain his personal care independently. The support plan provided information on David's strengths and abilities, as well as his areas of difficulty and recommendations to achieve his goals. This included a referral to a CHSP service provider for an occupational therapy assessment, and the delivery of time-limited personal care services.

The occupational therapist used the support plan to work with David and his personal carer to achieve his goals. Initially, personal care services were provided to David three times a week to assist him with showering. Over a four-week period, the CHSP service provider worked with David to develop specific strategies such as how to step in and out of the shower safely, to help him to build his capacity and regain confidence in showering. After four weeks of service David was confident to shower independently again, and the services were withdrawn.

BILL is a 75 year old man who lives at home with his wife Irene. Bill had not previously received any aged care services since he and Irene had always enjoyed good health. Recently Bill had an accident which had resulted in him spending time in hospital. Although Bill recovered well from his accident, it had left him feeling anxious about leaving the house. Also, his hospital stay and inactivity had reduced his physical fitness, preventing Bill from doing as much around the house and garden as he had done before.

Bill's wife Irene contacted My Aged Care and Bill was referred for an assessment. Bill's assessor worked with him to identify the things that he liked to do and what he no longer felt comfortable doing. A Support Plan was developed with Bill, which included some time-limited interventions with a restorative care focus, including referral:

- to physiotherapy or exercise physiologist (to develop a suitable strength, balance and endurance program)

- to an occupational therapist (to identify energy conservation strategies and/or suitable equipment to promote functional independence)

- for some time-limited home maintenance and domestic assistance.

Following this time-limited support, Bill now feels more confident living at home and has regained much of his former capacity to undertake the home maintenance and domestic chores that he used to do. Applying this short-term restorative care intervention approach enabled Bill to regain his strength and confidence and prevented a possible longer-term dependence on ongoing support services.

Assessment and support planning

The role of the assessor is to work with the older person to identify their needs and concerns, as well as their goals and aspirations. As part of the IAT, the assessment must include the older person's:

- current level of support (formal and informal) and engagement
- carer availability and sustainability
- health concerns and priorities
- functional status
- psychosocial and psychological concerns, and
- home and personal safety considerations.

The assessor then works with the older person to develop a Support Plan which focuses the support needed to assist them to achieve their goals. In developing a Support Plan with an older person, the assessor will:

- Focus on what an older person can do and discuss what they need to complete more difficult tasks, such as breaking down into simpler components.
- Discuss strategies to manage day-to-day tasks (e.g. transport planning to meet goals around the use of public transport to maintain usual activities).
- Explore the older person's opportunity for supporting independence through wellness and reablement approaches (e.g. can the older person benefit from time-limited

support and/or the use of specific aids and equipment or home modifications such as installing shower rails to build confidence and independence).

Developing a Support Plan with the older person helps to ensure that it accurately reflects the older person's needs and achievable goals and discusses with the older person the role they will need to play to achieve them how they feel about this (motivation). This will increase the likelihood that the older person will be motivated to work towards the goals they have identified, including supporting their independence through wellness and reablement approaches.

In some circumstances, where the assessment has identified that a short-term intervention is appropriate, the assessment organisation is required to take on a coordination role to ensure that all referrals in the Support Plan are linked to one or more service providers and that they will all be delivered within an agreed time frame.

For older people receiving wellness and reablement support, assessors should include review dates on the older person's Support Plan to monitor the older person's progress towards their goals and desired outcomes. The need for ongoing, or an adjustment in services will also be assessed. In these circumstances, CHSP service providers should provide time limited services in line with your Support Plan.

Older person scenario – wellness and reablement-focused assessment with support planning

CECELIA is an 81-year-old woman who lives alone. Before experiencing a stroke earlier in the year, Cecelia had been actively involved in her church and local community. However, following the stroke, Cecelia stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she had also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening.

Cecelia was referred to My Aged Care by her doctor and following the initial registration process and triage, a face-to-face assessment was organised. Cecelia's assessment helped to identify her strengths and capabilities as well as her needs. The resulting support plan was centred around Cecelia's own goals which included getting stronger, resuming her church activities, doing more about the house and getting back out in the garden. Cecelia's support plan included:

- referral to an allied health professional to assist with her goal of getting stronger,

- referral to a CHSP domestic assistance service provider to provide assistance with the more difficult household chores and to help Cecelia to identify which chores she could still manage to do on her own,

- assistance to identify and make contact with a pastoral care team member to discuss her continued interest in participating in church activities, and

- referral to a home maintenance service for discussion and planning to convert her garden to be safer and more accessible, and lower maintenance.

After mastering basic strength and balance exercises through a home exercise program designed by the allied health professional, Cecelia was eventually able to walk unaided inside her home. A more confident Cecelia then arranged a 'buddy' to drive her to and

from church activities. At the same time, the CHSP domestic assistance service provider worked with Cecelia to assist her to take on some of the easier housekeeping chores enabling her to remain more active and independent. Cecelia was also delighted to find that the new raised garden beds enabled her to access and maintain her garden more safely without affecting her enjoyment of the garden.

20. APPENDIX F – Aged care assessment workforce minimum qualifications

Assessment organisations must ensure their workforce has the appropriate training, skills and credentials to provide aged care needs assessments and related services. The below table lists the workforce credentials requirements for key roles within Assessment organisations referenced in Chapter 2. Training requirements for each role are detailed in the Workforce Learning Strategy.

Table 67. Aged care assessment workforce minimum qualifications

Role	Minimum qualification requirements
Triage Delegate	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of or eligible to be part of a relevant professional association. • at least one years' Aged Care Needs Assessment experience preferred. **Qualifications also recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • Aboriginal and Torres Strait Islander Health Practitioners with a Diploma of Aboriginal and/or Torres Strait Isander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. • Allied Health Assistants with a Diploma or above qualification in Allied Health Assistance and holds or is eligible for a Practising Member (certified) membership with the Allied Health Assistant's National Association. • Exceptions to the above qualifications may apply in certain circumstances, including (but not limited to) when the role is located in a remote area. Where an exception applies, a business case must be supplied to the Department for consideration.

Role	Minimum qualification requirements
Clinical Assessment Delegate	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of or eligible to be part of a relevant professional association. • At least one years' Aged Care Needs Assessment experience preferred. **Qualifications also recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • Aboriginal and Torres Strait Islander Health Practitioners with a Diploma of Aboriginal and/or Torres Strait Isander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. • Allied Health Assistants with a Diploma or above qualification in Allied Health Assistance and holds or is eligible for a Practising Member (certified) membership with the Allied Health Assistant's National Association. • Exceptions to the above qualifications may apply in certain circumstances, including (but not limited to) when the role is located in a remote area. Where an exception applies, a business case must be supplied to the Department for consideration.
Non-Clinical Assessment Delegate	• No minimum qualification. Current work experience in aged care or Aged Care Needs Assessment preferred. • At least one years' Aged Care Needs Assessment experience preferred.

Role	Minimum qualification requirements
Clinical Aged Care Needs Assessor	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the Australian Health Practitioners Regulation Agency (AHPRA) or part of or eligible to be part of a relevant professional association. • Minimum of one year demonstrated experience in Australia or overseas directly delivering services in aged care settings and/or to aged persons (such as geriatric evaluation, rehabilitation, palliative care, community nursing), including to people living with dementia. Note: An Enrolled Nurse may be considered for a clinical assessor role *only if they are under direct or indirect Registered Nurse supervision within the same organisation.* A business case is required. Aboriginal and Torres Strait Islander Health Practitioners with a Cert IV in Aboriginal and Torres Strait Islander Primary Health Care Practice may be considered for a clinical aged care needs assessor provided they are operating within their scope of practice. A business case is required for mainstream Single Assessment System organisations. *Note: Aboriginal and Torres Strait Islander Health Practitioners with a Cert IV in Aboriginal and Torres Strait Islander Primary Health Care Practice are not required to submit a business case to become a clinical aged care needs assessor in Aboriginal and Torres Strait Islander assessment organisations.* **Additional qualifications recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • A Cert IV or above in Aboriginal and/or Torres Strait Islander Primary Health Care Practice and is registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. • a Cert IV or above in Allied Health Assistance and holds or is eligible for a Practicing Member (Certified) class of membership with the Allied Health Assistants' National Association
Non-Clinical Aged Care Needs Assessor	• No minimum qualification. Previous knowledge or work experience in the aged care system preferred.

Role	Minimum qualification requirements
Aged Care Needs Assessment Team Leaders	• Tertiary* – in a health-related discipline directly related to health, aged care or related specialist area. E.g. registered nurses, medical officers, occupational therapists, physiotherapists and social workers. • Current unrestricted registration with the AHPRA or part of or eligible to be part of a relevant professional association. • At least one years' experience as a Clinical Aged Care Needs Assessor preferred. **Additional qualifications recognised for Aboriginal and Torres Strait Islander Assessment Organisations** • A Cert IV or above in Aboriginal and Torres Strait Islander Primary Health Care Practice. • an Enrolled Nurse under the supervision of a Registered Nurse may be considered for the Team Leader role. • Exceptions to the above qualifications may apply in certain circumstances, including (but not limited to) when the role is located in a remote area. Where an exception applies, a business case must be supplied to the Department for consideration.
Workplace Trainer	• At least one years' experience as an Aged Care Needs Assessor and as listed in the My Aged Care Workforce Learning Strategy. and/or • Training qualifications (such as a Cert IV or higher in training and assessment) or bachelor's degree in education, or higher.
Administrators (e.g. organisational and/or outlet administrators)	• At least three months' experience in aged care or Aged Care Needs Assessment preferred.
Contract Manager	Nil specified
Assessment Organisation Operational Manager	Nil specified
Administration Officer	Nil specified
Delegate Support	Nil specified

*Suitable tertiary qualifications are those that:

- Are relevant to health and/or aged care, and
- Have a practical component (i.e. clinical practice/practicum placement hours), and
- Include subjects that assess function/mobility, such as anatomy physiology, and/or health and wellbeing

21. APPENDIX G – AT-HM terms

Table 68. AT-HM terms and definitions

Term	Definition
Tier indicator	Item which aligns with an older person's function and home environment.
Mild/Minimal	Minor, infrequent and no significant impact.
Moderate	Medium, regular and has some impact.
Significant:	Considerable, frequent and complex with serious impact.
Progressive condition:	A medical condition that worsens over time, resulting in a range of limitations in function which can affect quality of life, daily living and community activities. (The 13 conditions listed below are all eligible AT-HM progressive conditions under Support at Home). These conditions include: • Cerebral Palsy • Epilepsy • Huntington's Disease • Motor Neurone Disease (MND) noting different phenotypes require different management • Multiple Sclerosis (MS) • Parkinson's Disease • Late effects of Polio • Spinal Cord Injury • Spinal Muscular Atrophy • Stroke • Acquired Brain Injury noting different types of brain injury require different management • Muscular Dystrophies and Muscular Atrophies.

22. APPENDIX H – Case studies- individuals experiencing homelessness or who are at risk of homelessness

The following case studies have been drawn from the department's 'Definition for Assessing Eligibility for Australian Government Funded Aged Care Services: Individuals Experiencing Homelessness or At Risk of Homelessness' policy. Triage Delegates may wish to use the case studies to assist in building their understanding of the definitions and whether they apply to an older person has made an application for an aged care needs assessment.

Case Study 1: Meets Eligibility Requirements

Greg, aged 52, has a history of living in abandoned houses, hotels, and squatting in empty homes. He has been residing in a boarding house for the past three years, where his living conditions have been relatively stable. However, Greg's mobility has gradually deteriorated, leading to multiple falls and subsequent hospital admission for fractures. Additionally, Greg suffers from post-traumatic stress disorder (PTSD) due to past trauma. Greg faces significant challenges in his daily life. He struggles with basic activities such as showering and preparing nutritious meals. He relies on a walker to move around the boarding house but is afraid to leave his room because the boarding house lacks the necessary aids to ensure his safety. Greg has no assets and survives on a small pension. Although he does not have a formal disability, his difficulties with daily living activities prevent him from living independently.

Greg meets the criteria for accessing Australian Government aged care services because Greg:

a. Is aged 50 years or older: Greg is 52 years old.
b. Has prematurely aged and requires services for their aged care needs: Greg's deteriorating mobility, multiple falls and PTSD indicate that he has prematurely aged and requires aged care services.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Greg has been living in a boarding house.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Greg has a history of unstable living conditions, including living in abandoned houses, hostels, and squatting in empty homes.
    - Stays in accommodation that falls below minimum community standards: the boarding house lacks necessary aids to ensure his safety, which may fall below minimum community standards.
d. Does not have the means to change their living arrangements: Greg has no assets and survives on a small pension, indicating he lacks the financial means to change his living arrangements.

Case Study 2: Meets Eligibility Requirements

Ann, aged 59, receives a small pension and has no assets. She suffers from chronic pain and declining mobility, which have led to several falls in the past six months. Struggling to pay rent, Ann was recently evicted from her private rental home due to rent arrears. Following the eviction, she moved in with a family member and is currently sleeping in the living room. Ann requires assistance with daily activities, including meal preparation and personal care, due to her health conditions.

Ann meets the criteria for accessing Australian Government aged care services because Ann:

a. Is aged 50 years or older: Ann is 59 years old.
b. Has prematurely aged and requires services for their aged care needs: Ann's chronic pain, declining mobility, and frequent falls indicate that she has prematurely aged and requires aged care services.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Ann is currently living with a family member.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Ann was recently evicted from her private rental home and is now sleeping in the living room of a family member's home, which can be considered a temporary or insecure living arrangement.
    - Stays in accommodation that falls below minimum community standards: Sleeping in the living room of a family member's home may fall below the minimum community standards for adequate housing.
d. Does not have the means to change their living arrangements: Ann has no assets and receives a small pension, indicating she lacks the financial means to change her living arrangements.

Case Study 3: Meets Eligibility Requirements

John, aged 60, has a history of living in shelter accommodation and his care, and is currently residing in a caravan in a remote location. He suffers from diabetes and related complication, requiring daily insulin. However, John struggles to manage his medication, leading to multiple hospital admissions. His living conditions have worsened and his health, as exposure to cold weather and lack of a heating system have negatively impacted him. John has no financial resources and is unable to work due to his chronic health conditions.

John meets the criteria for accessing Australian Government aged care services because John:

a. Is aged 50 or older: John is 60 years old.
b. Has prematurely aged and requires services for their aged care needs: John's diabetes, related complications and difficulty managing his medication indicate that he has prematurely aged and requires aged care services.
c. Has the following living arrangements:

- Lacks any adequate roof over their head: John's caravan in a remote location, lacking a heating system, can be considered unfit housing with substandard conditions.
- Has no security of tenure or moves between various forms or temporary or medium-term shelter: John's has a history of living in shelter accommodation and his care, and is now in a caravan, which can be considered a temporary or insecure living arrangement.
- Stays in accommodation that falls below minimum community standards: The caravan's lack of heating and remote location may fall below minimum community standards for adequate housing.

d. Does not have the means to change their living arrangements: John has no financial resources and is unable to work due to chronic health conditions, indicating he lacks the means to change his living arrangements.

Case Study 4: Does Not Meet the Eligibility Criteria

Peter, aged 53, has a disability and has always lived with his parents in their residential home. Recently, Peter's father has passed away, and his mother's health deteriorated leading her to move permanently to a residential aged care facility. Peter has been approved for a NDIS plan, which provides resources and funding for him to move to a NDIS group home with other participants. Although Peter did not own a home and had never lived outside the family home, he now has access to resources that allow him to move permanently into a stable and adequate home, where he can receive more appropriate support.

Peter does not meet the criteria for accessing Australian Government aged care services because Peter:

a. Is aged 50 or older: Peter is 53 years old.
b. Has permanently aged and requires services for their aged care needs: Peter has a disability, but the information does not indicate that he has prematurely aged or requires aged care services specifically related to ageing.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Peter has access to a stable and adequate home through the NDIS plan.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Not applicable, as Peter has a permanent arrangement in the NDIS group home.
    - Stays in accommodation that falls below minimum community standards: Not applicable, as the NDIS group home is described as table and adequate.
d. Does not have the means to change their living arrangements: Not applicable, as Peter has access to resources and funding through the NDIS plan to move to a stable home.

Case Study 5: Does Not Meet the Eligibility Criteria

Margaret (Maggie), aged 56, has been living in a boarding house for almost two years. Recently, she experienced a medical episode and was admitted to hospital. After receiving treatment, Maggie has now recovered and is medically stable with no residual care needs. Maggie has no assets and receives a small pension. Maggie also works on a casual basis in the local café and grocery shop.

Maggie does not meet the criteria for accessing Australian Government aged care services because Maggie:

a. Is aged 50 years or older: Maggie is 56 years old.
b. Has prematurely aged and requires services for their aged care needs: Maggie has recovered from her medical episode and is now medically stable with no residual care needs, indicating she does not require aged care services.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Maggie is living in a boarding house.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Meggie's boarding house could be considered a transitional housing arrangement, which may may fit this criterion.
    - Stays in accommodation that falls below minimum community standards: The boarding house could be considered accommodation that falls below minimum community standards.
d. Does not have the means to change their living arrangements: Maggie has no assets and receives a small pension, but she also works causally which may provide some means to change her living arrangements.

Given these points, Maggie does not seem to meet the criteria outlined in the definition for accessing aged care services, primarily because she has no ongoing aged care needs.

Case Study 6: Does Not Meet the Eligibility Criteria

Pedro, aged 59, has been living alone in a self-contained house in a caravan park for nearly seven years. Three years ago, Pedro was diagnosed with stage III colon cancer. He underwent surgery and chemotherapy, and after a period of recovery, he believed he was in remission. Unfortunately, Pedro's cancer returned, and he was diagnosed with stage IV colon cancer. He is now in the palliative stage. Despite his diagnosis. Pedro remains fully independent and manages his pain with medication. Pedro enjoys living in the caravan park community and receives regular visits from his family. Pedro does not have any care needs, lives independently in stable housing that meets housing standards, and is able to perform daily activities without assistance.

Pedro does not meet the criteria for accessing Australian Government aged care services because Pedro:

a. Is aged 50 or older: Pedro is 59 years old.

b. Has prematurely aged and requires services for their aged care needs: Although Pedro has stage IV colon cancer, he remains fully independent and does not have any care needs related to ageing.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Pedro lives in a self-contained house in a caravan park.
    - Has no security of tenure or moves between various forms of temporary of medium-term shelter: Not applicable, as Pedro has been living in stable housing for nearly seven years.
    - Staying in accommodation that falls below minimum community standards: Not applicable, as Pedro's housing meets standards, and he lives independently.
d. Does not have the means to change their living arrangements: This is not explicitly mentioned in Pedro's case, but his current living situation is stable and adequate.

Pedro does not seem to meet the criteria outlined in the definition for accessing aged care services, primarily because he does not have any aged care needs and lives independently in stable housing.

Case Study 7: Does Not Meet the Eligibility Criteria

Louise is 61 years of age. Louise's husband passed away three years ago and now lives by herself in a two-story house in a small community. Louise was in fairly good health condition but recently had an accident and was admitted to hospital where she underwent surgery. After a long recovery period, and still requiring visits to the physio, Louise is back home. Louise complained that she is not able to access the second floor where she has her bedroom. Louise was a teacher before she had kids and left her job to dedicate her time to her family. Louise is the owner of the house where she lives and has funds available, but she is struggling to live in the current house due to residual needs from the accident.

Louise does not meet the criteria for accessing Australian Government aged care services because Louise:

a. Is aged 50 years or older: Louise is 61 years old.
b. Has prematurely aged and requires services for their aged care needs: Louise has residual needs from her accident, but this does not necessarily indicate premature ageing or a need for aged care services specifically related to ageing.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as Louise lives in a two-story house.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Not applicable, as Louise owns her house.
    - Staying in accommodation that falls below minimum community standards: Not applicable, as her house does not fall below minimum community standards.

d. Does not have the means to change their living arrangements: Louise has assets and funds available, indicating she has the means to make necessary changes to her living arrangements.

Louise does not meet the criteria outlined in the definition for accessing aged care services.

Case Study 8: Does Not Meet the Eligibility Criteria

David is 58 years of age and lives permanently in a granny flat on his parent's property. David has a range of medical conditions, including severe obesity, type 2 diabetes and diabetic neuropathy, among others. David has had multiple hospital admissions in previous years and is currently in hospital following a five-week admission for the management of fluid retention. However, the hospital has now found David is medically stable for discharge. David has no assets and no other source of income apart from the Disability Support Pension.

David does not meet the criteria for accessing Australian Government aged care services because David:

a. Is aged 50 or older: David is 58 years old.
b. Has prematurely aged and requires services for their aged care needs: David has multiple medical conditions, but the information does not indicate that he has prematurely aged or requires aged care services specifically related to ageing. David's conditions appear to be medical rather than age-related.
c. Has the following living arrangements:
    - Lacks any adequate roof over their head: Not applicable, as David has access to a stable and adequate home living with his parents.
    - Has no security of tenure or moves between various forms of temporary or medium-term shelter: Not applicable, as David has been living permanently with his parents.
    - Stays in accommodation that falls below minimum community standards: There is no indication that David's accommodation falls below minimum standards.
d. Does not have the means to change their living arrangements: David has no assets and receives a small pension, indicating he lacks the financial means to change his living arrangements.

David does not meet the criteria outlined in the definition for accessing aged care services, primarily because David does not have any care needs related to ageing, nor has he prematurely aged due to experiencing homelessness.

23. APPENDIX I – IAT amendments guidance

Guidance for Delegates and Assessors on completing the IAT Amendments Notes Template

When returning an assessment for amendment, delegates and assessors must complete the IAT amendments notes template to clearly document all identified issues and changes. This ensures transparency, supports consistency, and enables effective independent review.

To support efficient review and processing, the notes field should contain clear and sufficient detail. Notes entries such as a blank field, a dash, placeholder text, or other minimal responses do not provide information to explain the requested amendments. The notes must provide a clear description of the requested amendment and sufficient detail to explain why each change is necessary.

The IAT amendment process is intended to correct identified errors, omissions or inconsistencies in assessment responses. It must not be used to alter or override a Support at Home classification that has been determined by the IAT algorithm.

How to Complete the IAT Amendments Notes Template (Delegates)

For each issue identified, delegates must record the following:

1. Required Amendment
Clearly outline what needs to be corrected:

- Specify the relevant domain, section, or field
- Clearly state what needs to be changed, added, or clarified
- Where applicable, notes should capture any offline discussions, ensuring entries remain concise and focused

2. Reason for Amendment

- Provide a brief, objective explanation for the required change. This may include:
- Inconsistencies within the assessment
- Missing or incomplete information
- Misalignment between documented evidence and IAT selections
- Gaps in documentation, including insufficient rationale for recommended services

How to Complete the IAT Amendments Notes Template (Assessors)

For each issue identified, assessors must record the following:

1. Changes Made

- Clearly document what changes have been made to the IAT or Support Plan
- Specify the relevant domain, section, or field where the amendment has occurred

2. Changes Not Made

- Where a requested amendment has not been implemented, record this clearly

- Provide a concise, evidence-based justification outlining the reason

Table 69. Examples of responses for IAT amendments Notes Template (Assessor and Delegate)

IAT section	Notes to assessor to review IAT (from Delegate)	Notes to delegate on the IAT review (from Assessor)
Assessment Details:	Medical practitioner selected but no detail. Add geriatrician (Dr Lam) detail in free text box	Updated to include detail on Dr Lam in free text box.
Reason for Assessment:	“Referral from a health professional” and “Change in living arrangements” selected with no supporting free text. Add who referred, from where, and nature of change to support selections.	Added referral details including referring GP and reason.
Carer profile:	Carer strain/involvement referenced elsewhere but not recorded. Complete carer profile to ensure consistency across domains.	Updated *Carer profile* to record daughter’s support and noted carer strain.
Medical and Medications:	'Osteoporosis’ referenced in Function but not selected. Add in health condition and “Add as other consideration” to align domains.	Selected ‘Osteoporosis’ under health conditions and added as “Other consideration.”
	Allergies/sensitivities referenced elsewhere but not selected. Add detail and record to reflect documented evidence.	Added allergy and added supporting detail.
Function:	“Get to places out of walking distance” marked “Completely unmet” despite evidence. Amend to “Completely met” to reflect ability to drive.	Updated to “Completely met.” for ‘get to places out of walking distance.’
	“Prepare meals” marked “Without help.” Amend to “With some help” as assistance is documented by daughter.	Updated to ‘With some help’ for ‘prepare meals’ and recorded as functional need.
	Limited detail for “Transfers.” Add detail to reflect identified difficulty with using bed rail.	Added detail under ‘Transfers.’
	Add “Walk” and “Climb stairs” as functional needs based on evidence.	Added both as functional needs for ‘walk’ and ‘climb stairs.’
Physical, personal health & Frailty:	Need more detail under ‘Frailty observations’ in free text field	Added additional detail on frailty free text field.
	Include tick on ‘Asthma’ as listed under health conditions	Ticked Asthma.
Social:	Documented as ‘lonely, down and socially isolated?’ ‘most of the time.’ Complete DSSI or provide evidence for lack of completion.	Completed DSSI over telehealth.

	Frequent loneliness/isolation selected; however, evidence shows regular social contact and activities and DSSI entries inconsistent., Update to align.	DSSI updated to align with assessment information and completed via telehealth.
Cognition:	Lack of information on cognitive difficulties. Add detail in free text field.	Additional information added in free text field.
Behaviour	'No' recorded to 'Does the client experience feeling aggressive, agitated or have found themselves wandering?' but agitation and short temper are noted elsewhere. Amend to align, add detail, and record as "Other considerations."	Response changed to 'Yes' for 'Does the client experience feeling aggressive, agitated or have found themselves wandering?,' additional information added and 'Add as other consideration' selected.
	'Yes' recorded to 'Does the client experience feeling aggressive, agitated or have found themselves wandering?;' but, no evidence of aggression, agitation, or wandering. Amend to align and update/remove related notes or "Other considerations."	Updated to 'No' for 'Does the client experience feeling aggressive, agitated or have found themselves wandering?' in line with assessment information.
Psychological:	Low mood noted in Ax summary but not reflected. Update responses for alignment with assessment evidence.	Aligned with evidence on low mood.
	"Nearly every day" lacks supporting detail. Add explanatory notes or amend. Add "Add as Other consideration"	Additional notes added in free text field and 'Add as other consideration' selected.
Home and personal safety:	"Moderate environmental hazards requiring modification" lacks detail. Add observations to support rating or amend.	Additional notes added for environmental hazards in free text field.
	Home maintenance marked "No" despite concerns in Ax summary. Amend and "Add as Other consideration."	Updated to 'Yes' with additional detail and added as other consideration.
	Unstable accommodation recorded with limited evidence. Add detail for selection and add as a complexity indicator.	Additional information added for unstable accommodation and added as a complexity indicator.
Financial or legal:	"Yes" selected for 'financial and legal issues' with no supporting detail. Add explanatory notes or amend to justify response.	Added notes to support 'Yes' selection in 'financial and legal issues.'
	Power of attorney referenced elsewhere but not recorded. Update to align with evidence.	Updated to reflect evidence re POA.
Support Considerations:	Elder abuse risk selected without detail. Add rationale to support assessment decision.	Notes updated to support selection.

	Cognitive impairment impacting self-care documented elsewhere. Review and amend and add as a complexity indicator.	Amendment made and added as a complexity indicator.
	“Urgent service provision’: “Yes” not supported by evidence. Review and amend to reflect risk level accurately.	Updated to ‘No’ for ‘urgent service provision’
Validated Assessment Tools:	GP-Cog/DEMMI-modified not completed. Add evidence to justify why not being completed.	Added additional evidence on why both screening tools not completed in free text fields in Cognition and Function section.
Other: (Support plan changes, grammar, spelling etc)	Ax summary has Inconsistent use of terms (e.g. “support worker” vs “carer”). Amend to make it clear who is being referenced.	Ax summary amended to reflect ‘carer.’
	Spelling mistakes and grammatical errors throughout free text fields. Review and update.	Spelling and grammar corrected in free text fields.
		Previous recommendations removed in Support Plan and updated to align with new IAT Outcome.