

Assessor Portal User Guide 6 - Completing an Assessment

This guide explains the roles and responsibilities of assessors when completing an aged care assessment in **My Aged Care**. It covers:

- **Non-clinical assessors**, who can complete **Home Support Assessments**
- **Clinical assessors**, who can complete **Comprehensive Assessments**

Assessors can complete the **Integrated Assessment Tool (IAT)** using:

- the **Assessor Portal** (covered in this guide)
- the **Aged Care Assessor App**, and upload the assessment when they next have internet access
- a printed or blank copy of the IAT, and enter the information into the Assessor Portal after completing the assessment

If you only have an **Organisation Administrator** or **Outlet Administrator** role, you cannot view or complete assessments in the Assessor Portal.

For detailed instructions on completing an assessment, refer to the [Integrated Assessment Tool \(IAT\) User Guide](#).

! On 1 November 2025, the *Aged Care Act 2024* and the Support at Home program come into effect with significant change to support plans in the IAT.

To ensure the right IAT is used, and triage can continue for priority referrals, any assessments in the following statuses already started prior to 1 November 2025 and in progress on 1 November 2025 must be restarted:

- Triage complete, main assessment not started
- Triage complete, main assessment in progress (includes incomplete support plan)
- Main assessment completed, awaiting delegate decision (comprehensive assessments).

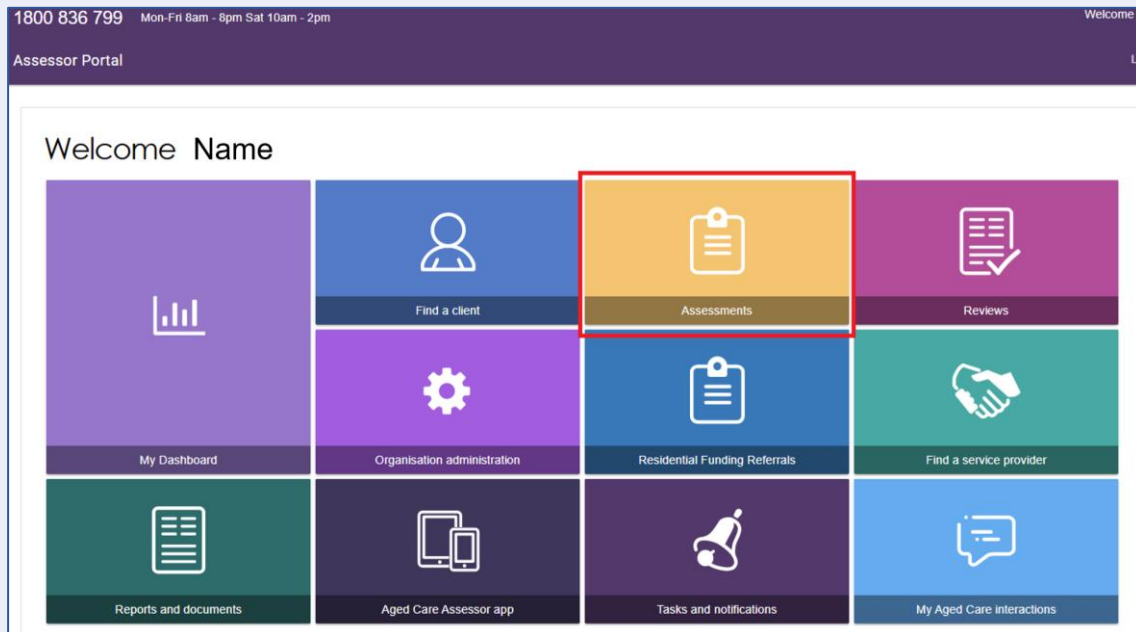
For information on the **Restart Assessment Process**, please refer to *Management of active assessments for 1 November 2025 transition – Standard Operating Procedure and Restarting In Progress Assessments for Support at Home* (instructional video).

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Viewing assessments

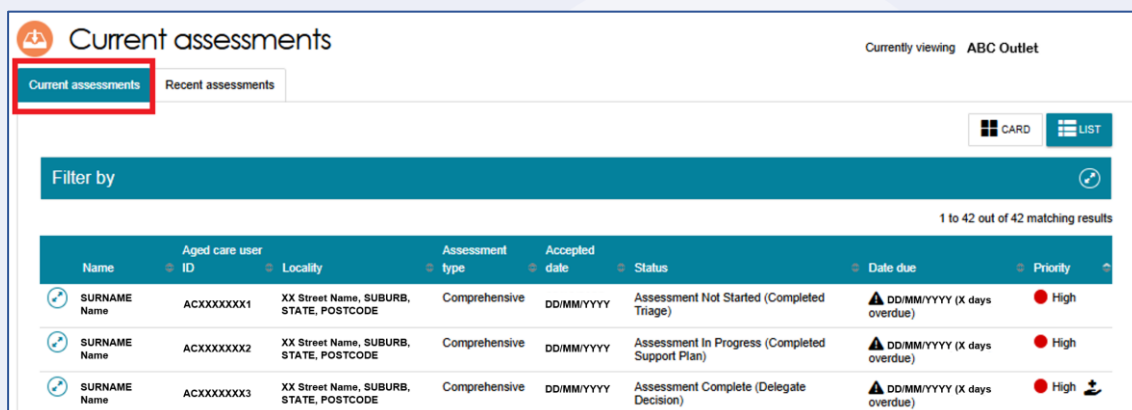
Follow these steps to view an assessment:

1. Select **Assessments** on the homepage.



2. From the Assessments tile, assessors can view all assessments assigned to them under the **Current Assessments** tab. This tab includes assessments with the following statuses:

- Triage not started
- Assessment not started
- Assessment in progress
- Assessment completed but not yet finalised
- Assessment awaiting delegate decision (not applicable for reviews)
- Delegate decision completed but not finalised (not applicable for reviews).
- Assessments returned to the assessor from the delegate.



For more information about assessments returned to the assessor from the delegate, refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#).

- ! To view the next Key Performance Indicator milestone (for example, Finalised Support plan) and due date for an assessment, go to the client's referral card.

Name
SURNAME

SUBURB, STATE, POSTCODE
 Aged care user ID: ACXXXXXXX1
 Date accepted: DD Month Year
 Completed Support Plan due by DD Month Year

Comprehensive
 118 days overdue

Assessment In Progress
 High

3. The **Recent assessments** tab shows assessments that have been finalised, cancelled, and/or closed. It also contains completed and cancelled Support Plan Reviews.

Recent assessments
Currently viewing ABC Outlet

Current assessments

Recent assessments

CARD

LIST

Filter by

1 to 20 out of 20 matching results

Name	Aged care user ID	Locality	Assessment type	Completed/cancelled date	Status	Priority
SURNAME Name	ACXXXXXXX1	XX Street Name, SUBURB, STATE, POSTCODE	Home Support	DD Month Year	Finalised	High
SURNAME Name	ACXXXXXXX2	XX Street Name, SUBURB, STATE, POSTCODE	Home Support	DD Month Year	Finalised	Medium
SURNAME Name	ACXXXXXXX3	XX Street Name, SUBURB, STATE, POSTCODE	Comprehensive	DD Month Year	Finalised	Low
SURNAME Name	ACXXXXXXX4	XX Street Name, SUBURB, STATE, POSTCODE	Comprehensive	DD Month Year	Finalised	Low

- ! You can sort and filter assessments. For more information refer to the [My Aged Care – Assessor Portal User Guide 3 – Managing referrals for assessment and support plan reviews](#).

Starting an assessment

1. To start an assessment, select a client from the **Assessment Not Started** heading, and then select the double arrow icon on the top right-hand corner of the client card.

The screenshot shows the 'Current assessments' page. At the top, there's a header with 'Current assessments' and 'Currently viewing: Aussie Healthcare Outlet'. Below this are tabs for 'Current assessments' and 'Recent assessments'. A 'Filter by' bar is present. Below the filter bar, there's a sorting section with 'Sort by: Assessment Priority' and 'in order of: High to Low', followed by a 'GO' button. Below this, it says 'Current sort order is Assessment Priority' and '1 to 5 out of 5 matching results'. The main section is titled 'Assessment Not Started'. It contains a client card for 'Name SURNAME'. The card has a red box highlighting a double arrow icon in the top right corner. Below the name, there's a section with 'Aged care user ID: ACXXXXXXX1', 'Date accepted: DD Month Year', and 'Completed Triage due by: DD Month Year'. At the bottom of the card, there's a section with 'Home Support' and 'Due in 3 days', and a green bar with 'Assessment Not Started' and a dropdown menu set to 'Low'.

The client card shows a summary of the client's information. Assessors can view read-only copies of previous screenings, triages, and assessments; as well as referral-related attachments and the client's support plan, if one is available.

- ! When you open the client card, the Support plan status is shown as **Triage Completed**. To view details from the screening and triage, select the magnifying glass icon.

The screenshot shows the client card details view. At the top, there's a header with 'Name SURNAME' and a close button. Below this is a light blue box with an information icon and the text: 'Please confirm that Name SURNAME, DD Month Year, XX Years, ACXXXXXXX1 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.' Below this, there's a section with 'Aged XX (DD Month Year), Gender' and 'Referred from [Referral Source] on DD Month Year'. There are two columns of details. The left column is titled 'Preferences' and 'Assessment details'. The right column is titled 'Completed Triage due by', 'Client story', and 'Comments'. At the bottom, there's a section for 'Support plan' and 'Home Support Assessment'. The 'Support plan' status is 'Triage Completed' with a green circle and a magnifying glass icon. The 'Home Support Assessment' status is 'Triage Completed' with a green circle and a magnifying glass icon. A red box highlights the magnifying glass icon next to the 'Support plan' status.

- For comprehensive assessments, clinical assessors can select the assessment setting before starting the assessment. Select the **Edit** (pencil) icon next to **Assessment Setting**.

Name SURNAME

Please confirm that Name SURNAME, DD Month Year, XX Years, ACXXXXXXX1 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Aged XX (DD Month Year), Gender Referred from [Referral Source] on DD Month Year

Preferences
No preference was recorded

Completed Triage due by DD Month Year

Assessment details

Assessment type Comprehensive

Assessment reason DD/MM/YYYY

Assessment setting Non-Hospital

Assessor Name SURNAME

Triage conducted by Name SURNAME

Support plan Triage Completed

Client story DD/MM/YYYY

VIEW ALL 4 CLIENT NOTES

Comments

- The **Assessment setting** pop up appears. Select **Hospital** or **Non-Hospital** and then select **Save**.

Assessment setting

If you edit the assessment setting for this client, you must also edit the assessment setting in the IAT.

Assessment setting* ?

☐ Hospital

☒ Non-Hospital

SAVE **CANCEL**

4. The **Assessment setting** entered here must be the same as the value recorded in the Integrated Assessment Tool (IAT). If either value is changed, clinical assessors must update both fields so they match.

Before starting an assessment, clinical assessors can change a Home Support Assessment to a Comprehensive Assessment. To do this, select **CONVERT TO COMPREHENSIVE ASSESSMENT**.

Aged XX (DD Month Year), Gender

Referred from [Referral Source] on DD Month Year

Preferences
No preference was recorded

Assessment details

FNAO-preference No

Assessment type Home Support

Assessment reason Self-Referral

Assessor Name SURNAME

Triage conducted by Name SURNAME

Support plan ☒ Triage Completed

Home Support Assessment ☒ Triage Completed

Completed Triage due by DD Month Year

Client story
No client story was recorded

Comments

Cohabitant details
Name SURNAME

VIEW FULL CLIENT RECORD

VIEW CLIENT REPORT

REFER URGENT SERVICES

CONVERT TO COMPREHENSIVE ASSESSMENT

START ASSESSMENT

FLAG AS END OF LIFE

5. The reason for the change will be automatically filled. Enter your **Reason or comments** about converting the assessment.

Non-clinical assessors who want to change a Home Support assessment to a Comprehensive assessment must also enter the name of the supervising clinical assessor.

Convert to comprehensive assessment

You are about to convert the assessment type from Home Support to Comprehensive for Name SURNAME

Assessments should only be converted if the client's needs exceed the level of care that can be provided through Home Support assessments (e.g. home support services). Once this assessment has been converted to a Comprehensive assessment, you can recommend for all aged care services. Please note it will not be possible to revert it back to a Home Support assessment.

Are you sure you want to proceed?

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

Reason for change *

High level care needs

Reason or comments: *

0 / 255

Supervising assessor *

YES, CONVERT ASSESSMENT

NO, CANCEL

6. Once you have completed the required information, select **YES, CONVERT ASSESSMENT** to continue. After an assessment has been converted to a Comprehensive assessment, it cannot be changed back to a Home Support assessment. The assessment type will then be shown as a Comprehensive Assessment.

Convert to comprehensive assessment

You are about to convert the assessment type from Home Support to Comprehensive for **Name SURNAME**

Assessments should only be converted if the client's needs exceed the level of care that can be provided through Home Support assessments (e.g. home support services). Once this assessment has been converted to a Comprehensive assessment, you can recommend for all aged care services. Please note it will not be possible to revert it back to a Home Support assessment.

Are you sure you want to proceed?

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

Reason for change *
High level care needs

Reason or comments: *
0 / 255

Supervising assessor *

YES, CONVERT ASSESSMENT NO, CANCEL

7. The assessment type will now be shown as Comprehensive Assessment. When you are ready to begin, select **START ASSESSMENT**.

Name SURNAME

Please confirm that Name SURNAME, DD Month Year, XX Years, ACXXXXXXX1 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

Aged XX (DD Month Year), Gender Referred from [Referral Source] on DD Month Year

Preferences
No preference was recorded

Completed Triage due by DD Month Year

Assessment details

Assessment type Comprehensive

Assessment reason Self-Referral

Assessment setting Non-Hospital

Assessor Name SURNAME

Triage conducted by Name SURNAME

Support plan Triage Completed

Comprehensive Assessment Triage Completed

Client story
No client story was recorded

Comments

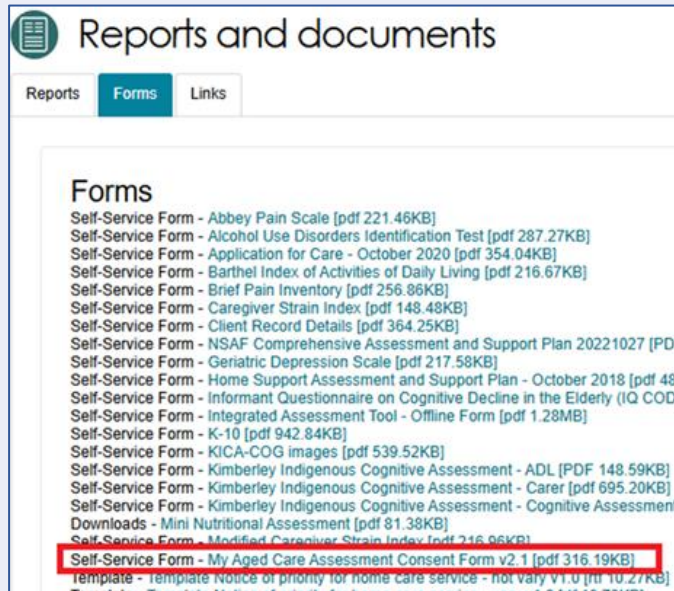
VIEW FULL CLIENT RECORD VIEW CLIENT REPORT

REFER URGENT SERVICES **START ASSESSMENT** FLAG AS END-OF-LIFE

8. Record client consent before starting the assessment.

Read the relevant consent script from the **My Aged Care Assessment Consent Form** to the client, and record their response. If you believe the client may not have the capacity to provide consent, complete the form with the client's confirmed supporter or supporter guardian recorded in My Aged Care.

Download the My Aged Care Assessment Consent Form from the **Reports & Documents** tile in the Assessor Portal.



9. If the client gives consent, select the relevant consent options in the **Consent for Assessment pop-up** (shown in the next page) and then select **CONTINUE**. During this step, obtain the signed copy of the Aged Care Assessment Consent Form.

! If the client does not give consent, the system displays a warning message advising that you cannot continue with the assessment. Enter the reason the assessment could not be completed. If you select **Other, please specify**, provide additional details in the free-text field.

Select **SAVE AND CLOSE** to cancel the assessment.

Consent for Assessment

Consent of the privacy notice must be obtained before proceeding with the assessment. Information about other people will be included in your My Aged Care client record and will be handled in the same way as your own personal information - being for the purpose of providing aged care services to you.

- The information you provide may also be recorded in the assessment organisation's IT systems and will be used and disclosed by the assessment organisation for the purpose of determining your eligibility for aged care services.
- The assessor may share your personal information with other organisations to manage the support you need, for example, the Department of Health and Aged Care, aged care or health providers, Services Australia and state and territory services.
- As we go through the assessment, please tell me if you do not want any of your information to be recorded. We can discuss how to manage this further.
- You can change your mind and withdraw your consent to participate in the assessment at any time. However, this will mean the assessor cannot complete your assessment for aged care services. You will need to arrange your own aged care services.
- You can view the privacy notice which is set out at [privacy notice web address](#) as well as the My Aged Care privacy policy on the My Aged Care website at [myagedcare.gov.au](#) for more information on how we handle your personal information.
- Do we have your consent to assess the eligibility of **Name SURNAME** for aged care services?

Consent Obtained From *

Consent was not given

Please select a reason for not providing the consent *

Client unable to consent

Please be advised that without capturing the consent, you cannot proceed any further with the Assessment. If sure, then select 'Save and Close'. This will reject the referral.

SAVE AND CLOSE **CANCEL**

Consent for Assessment pop-up

Consent for Assessment

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

Information

Informed consent is necessary to meet requirements of both the *Privacy Act 1988* with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under *Chapter 7, Part 2 of the Aged Care Act 2024*.

Prior to starting the assessment, the assessors must read out the consent script to the client and record the client's consent for an aged care assessment. The script is to be used as a guide to assist the client in providing informed consent and can be tailored to ensure that the information is understood by the client (note that you must bring the contents of the privacy notice, including the web address to the client's attention). If the assessor significantly deviates from the script, this should be noted in the client's My Aged Care record.

If there is a suggestion that the client lacks capacity, obtain consent from the client's registered supporter, decision-making supporter or guardian in My Aged Care.

When and how to seek consent?

Assessors must seek and gain informed consent from the client (or supporter, decision-making supporter or guardian) either prior to or when commencing the assessment or reassessment.

The assessor can also use the 'Notes' section in the client's record to:

- record any detail of the circumstances regarding the handling of a client's personal information; and
- record any instructions relating to the assessor's conversation with the client (or supporter, decision-making supporter or guardian with respect to informed consent).

Does client have capacity to give informed consent?

Prior to obtaining consent, the assessor must determine whether the client has the capacity to understand and communicate their consent by determining if:

- The client can provide their informed consent independently,
- The client can provide their informed consent with the assistance of their supporter, decision-making supporter, or guardian,
- The client lacks capacity and requires their decision-making supporter or guardian to provide consent on their behalf (this consent cannot be provided by their supporter).

If a supporter, decision-making supporter or guardian (includes other persons in a similar position to a guardian as defined under subsection 28(2) of the Aged Care Act 2024) is required, they must be registered as such in My Aged Care prior to obtaining the client's consent.

For more information, please see the [My Aged Care Assessment Manual](#)

Script to be read.

In giving your consent for an aged care assessment, you understand that:

- The assessor¹ will collect information that allows them to assess your eligibility for aged care services.
- For your assessment, the assessor will collect personal information about you, such as information about your name and address, and information about your health and care needs.
- The information you provide will be recorded in your My Aged Care client record and will be used and disclosed by the assessment organisation, the Department of Health and Aged Care as well as any aged care providers while providing aged care services to you.
- If it is required for your assessment, the assessor may need to collect information from your General Practitioner, other health professionals, your family or carers.
- As part of your assessment, if you provide the assessor with personal information about other people such as your family or your support person, you confirm that you have obtained the other person's consent and that you have brought the contents of the privacy notice which is set out at [privacy notice web address](#) to their attention. Information about these other people will be included in your My Aged Care client record and will be handled in the same way as your own personal information - being for the purpose of providing aged care services to you.
- The information you provide may also be recorded in the assessment organisation's IT systems and will be used and disclosed by the assessment organisation for the purpose of determining your eligibility for aged care services.
- The assessor may share your personal information with other organisations to manage the support you need, for example, the Department of Health and Aged Care, aged care or health providers, Services Australia and state and territory services.
- As we go through the assessment, please tell me if you do not want any of your information to be recorded. We can discuss how to manage this further.
- You can change your mind and withdraw your consent to participate in the assessment at any time. However, this will mean the assessor cannot complete your assessment for aged care services. You will need to arrange your own aged care services.
- You can view the privacy notice which is set out at [privacy notice web address](#) as well as the My Aged Care privacy policy on the My Aged Care website at [myagedcare.gov.au](#) for more information on how we handle your personal information.
- Do we have your consent to assess the eligibility of Patricia THOMPSON for aged care services?

Consent/Objection Form A

Select one

Select one

The client

The client with support person

Consent was not given

The supporter/guardian

10. You can **Pre-populate the IAT** with existing client information or start a blank assessment.

For new clients who have not completed a screening or have had a previous assessment, you can pre-populate the IAT using information from the triage.

If the client has completed a screening, you can also select to pre-populate the IAT with information from the screening. If the client has had a previous assessment you can choose to use information from that assessment as well.

After selecting the information that you want to use, select **CONFIRM SELECTION**.

Pre-populate or start a blank assessment

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

By selecting 'Triage(Completed on DD MM YYYY)' the new assessment will be pre-populated with answers from the Triage completed on DD MM YYYY and if applicable the Comprehensive Assessment completed on DD MM YYYY

Please select 'Blank Assessment' if you want to start the new assessment with no pre-population. Note that you will not be able to pre-populate the new assessment after a blank assessment has been created.

Please select*

☒ Triage (Completed on DD MM YYYY) and ☒ Comprehensive Assessment (Completed on DD MM YYYY)

☐ Blank Assessment

Note: The completed Triage decision will be viewable as a completed screen in the IAT.

CONFIRM SELECTION CANCEL

If you do not wish to pre-populate the IAT select **Blank Assessment**.

! If you select **Blank Assessment**, you cannot reverse this decision during the assessment.

Pre-populate or start a blank assessment

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

By selecting 'Triage(Completed on DD MM YYYY)' the new assessment will be pre-populated with answers from the Triage completed on DD MM YYYY and if applicable the Comprehensive Assessment completed on DD MM YYYY

Please select 'Blank Assessment' if you want to start the new assessment with no pre-population. Note that you will not be able to pre-populate the new assessment after a blank assessment has been created.

Please select*

☐ Triage (Completed on DD MM YYYY) and ☐ Comprehensive Assessment (Completed on DD MM YYYY)

☒ Blank Assessment

Note: The completed Triage decision will be viewable as a completed screen in the IAT.

CONFIRM SELECTION CANCEL

11. Review and update the client's demographic information, including:

- Whether the assessment is being completed remotely
- The client's personal details and background
- Whether the client would prefer a First Nations Assessment Organisation (if available)
- Government identification details such as Medicare card number.

The system pre-populates these details from the triage record. Update any information if needed.

After confirming the correct details are correct, select **SAVE AND CONTINUE TO ASSESSMENT**.

Demographic details

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

Please check the following information for this client before starting the assessment. All fields must be completed before the assessment can begin.

☐ Remote Assessment ?

Personal details & Identification

First name *

Name

Middle name

Last name *

SURNAME

Address:

XX Street Name, SUBURB, STATE, POSTCODE

Contact details:

not specified

Medicare number:

To change the above details,
[view the full client record.](#)

Background

Please enter the date of birth. If the date of birth is not known, please enter an estimated age in the Age field. This will then be used to automatically determine an approximate date of birth for the Client. *

Date of birth

DD/MM/YYYY

or

Estimated age

AGE

Gender *

Gender

Country of birth *

Country

SAVE AND CONTINUE TO ASSESSMENT

CANCEL

- ! It is important to ensure that the client's **Aboriginal or Torres Strait Islander identity** is accurately captured, as this will trigger the system to display Validated Assessment Tools that are appropriate to use with First Nations people if required.

Does the client identify as an Aboriginal or Torres Strait Islander?

Indigenous origin:

☐ No - Neither

☒ Yes - Aboriginal

☐ Yes - Torres Strait Islander

☐ Yes - Both

☐ Not stated/inadequately desc

Does the client prefer a First Nations Assessment Organisation for their assessment?

Yes

A client's **Medicare card** number must be correctly entered to ensure that their My Health Record can be successfully linked if they consent to do so.

Medicare card number			
4 digits	5 digits	1 digit	Reference

- ! Select **Remote Assessment** only when you complete a face-to-face assessment in a remote (MM6) or very remote (MM7) area. Recording remote assessments accurately helps improve reporting and supports future planning for clients in remote communities. To check whether a client lives in a MM6 or MM7 area, use the [Health Workforce Locator](#):

1. Select Start the Locator Now from the home page
2. Enter the client's address
3. The MM number displays in the Summary section.

XX Street Name, SUBURB, STATE, POSTCODE

was classified as:

Summary	Classifications
District of Workforce Shortage for Specialists	
Anaesthetics	Yes
Cardiology	Yes
Diagnostic Radiology	Yes
General Surgery	Yes
Medical Oncology	Yes
Obstetrics & Gynaecology	Yes
Ophthalmology	Yes
Psychiatry	Yes
Catchment: Mackay (31202)	
Distribution Priority Area for GPs	
IMGs / FGAMS	Yes
Bonded doctors	Yes
Catchment: Sarina	
Modified Monash Model	
2015	MM 5
2019	MM 5
2023	MM 5
ASGS Remoteness Areas	
2011	Outer Regional Australia - RA Code 3
2016	Outer Regional Australia - RA Code 3
2021	Outer Regional Australia - RA Code 3

12. If an assessor needs to update a client's demographic details after they have commenced the assessment, they can do so from the **CLIENT DETAILS** tab of the Client Record by navigating through the **FIND A CLIENT** tile from the homepage.

Name SURNAME
Gender, XX years old, DD Month Year, ACXXXXXX01
XX Street Name, SUBURB, STATE, POSTCODE

Primary contact: Name SURNAME
No support relationships recorded

Client details [REFER THIS CLIENT FOR ASSESSMENT](#) [VIEW CLIENT REPORT](#)

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

Notes Tasks and Notifications Residential Funding Classifications

About Name [NOTIFY MY AGED CARE OF A DEATH](#)

Personal information

Born [DD Month Year], [Nationality], born in [Country Name], [Marital Status], lives alone.
Status: Active
Preference for a First Nations Assessment Organisation to do their assessment: No

Identity documents (ID)

Aged Care ID: ACXXXXXX01

Identity Status
IHI Record status: Not Attempted
Identity match status: Not Attempted
Wallet check status: Incomplete
Client association status: Not Attempted

To contact Name

13. A record of any previous screenings or assessments will be accessible through the **PLANS** tab of the client record under **ASSESSMENT HISTORY**.

Plans [REFER THIS CLIENT FOR ASSESSMENT](#) [VIEW CLIENT REPORT](#)

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

Notes Tasks and Notifications Residential Funding Classifications

Current Episode
Episode ID: ABC123
DD Month Year - Present
[SUPPORT PLAN](#)

Recommendations

- Services under the MPSP
- Services under the NATSIFACP
- Case Management
- Nursing care
- Residential Permanent
- Residential Respite Care

Assessment history

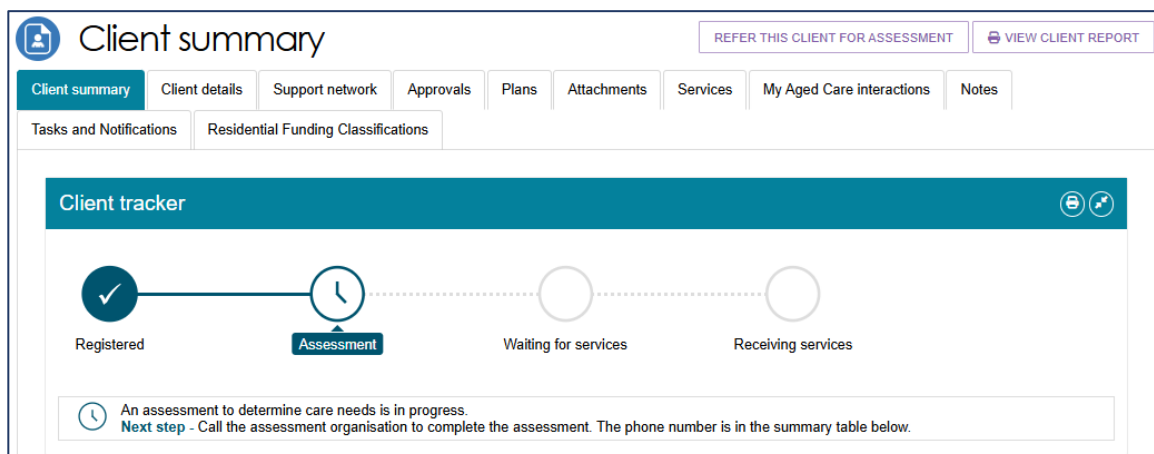
- Comprehensive Assessment DD MM YYYY
- Screening DD Month Year

Plan history

[Support plan as at DD Month Year](#)
[Support plan as at DD Month Year](#)

Completing an assessment

- ! The **Client Journey Tracker** is a visual tool that shows where a client is in their My Aged Care journey and what happens next. It displays above the Client Summary. During the assessment, the client's tracker displays: "An assessment to determine care needs is in progress."



- ! The **Integrated Assessment Tool (IAT)** uses an algorithm to help assessors make consistent recommendations based on a client's needs. The algorithm analyses the client's assessment responses and current aged care approvals, then recommends appropriate aged care services. After you finalise the IAT, the recommended services appear on the **Support Plan and Services** page under the **Goals and Recommendations** tab.

In some cases, the system also displays information messages to indicate that the client may be suitable for:

- the Restorative Care Pathway
- Support at Home
- Assistive Technology
- Home Modifications.

1. When you start an assessment, the Demographic Details page opens. The system may pre-fill some information from an earlier triage, screening, or assessment. Review the details, update them if needed, and make sure all required fields are complete. When you are ready to continue, select **SAVE AND CONTINUE TO ASSESSMENT**.

Demographic details

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

Please check the following information for this client before starting the assessment. All fields must be completed before the assessment can begin.

☐ Remote Assessment ?

Personal details & Identification

First name *
Name

Middle name

Last name *
SURNAME

Address:
Contact details:
not specified
Medicare number:
To change the above details,
[view the full client record.](#)

Background

Please enter the date of birth. If the date of birth is not known, please enter an estimated age in the Age field. This will then be used to automatically determine an approximate date of birth for the Client. *

Date of birth
DD/MM/YEAR

or

SAVE AND CONTINUE TO ASSESSMENT CANCEL

2. The Assessment Details page opens. Key client information appears at the top of each assessment page for quick reference.

Home | Assessments | Assessment

Name SURNAME

Gender, XX years old, DD Month Year, ACXXXXXX01

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

Physical, Personal Health & Frailty

Social

Cognition

Behaviour

Psychological

Home & Personal Safety

Financial or Legal

Support Considerations

Assessment Details

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

Date of assessment * DD/MM/YY

Participants consulted prior to the assessment *

Yes No

Mode of assessment *

Face-to-face Over-the-phone Via tele-health

Assessment setting *

Please select...

Details

0 / 500

Clear Page Information

- To view information collected during triage, select **TRIAGE** from the navigation bar. The triage information opens in read-only mode.

The screenshot shows the 'Assessment Details' page. On the left, a navigation bar contains 'Triage', 'Assessment Details', 'Reason for Assessment', and 'Carer Profile'. The 'Triage' item is highlighted with a red box. The main content area is titled 'Assessment Details' and includes a 'Save Assessment' button at the top left and a 'Clear Page Information' button at the top right. Below the title, it states 'All fields marked with an asterisk (*) are required.' and shows a 'Date of assessment' field with a calendar icon and a 'DD/MM/YY' input field.

- The navigation bar moves with you as you scroll through the assessment. A tick appears next to the section in the navigation bar when you have completed that section.

The screenshot shows the 'Assessment Details' page. The navigation bar now has 'Assessment Details' selected, indicated by a green checkmark icon next to it. The other items are 'Reason for Assessment' and 'Carer Profile'.

- ! To protect client information, the system automatically logs you out after a period of inactivity. If there is no activity for **25 minutes**, the system displays a warning message. If the system remains inactive for another **5 minutes**, it automatically logs you out. You will then need to log in again before continuing the assessment.

Assessment features

- To remove any information you have entered on the current page, select **Clear Page Information** in the top-left corner of the page.

The screenshot shows the 'Assessment Details' page. The 'Clear Page Information' button in the top right corner is highlighted with a red box. The navigation bar on the left now includes 'Medical and Medications' at the bottom. The main content area remains the same.

- A pop-up message appears. Select **Yes, clear page information**. To remove all information entered on the page.

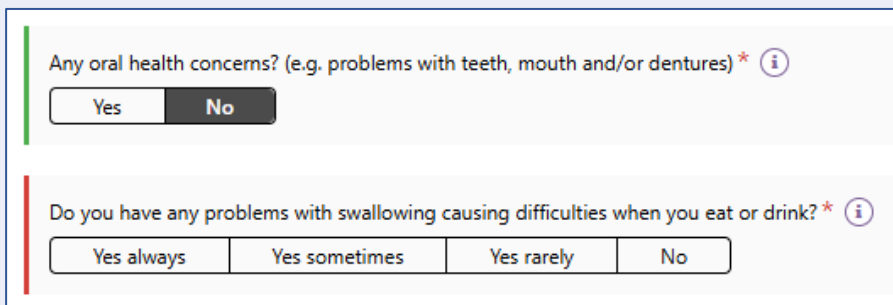
The screenshot shows a purple pop-up message titled 'Clear page information'. It contains the text: 'Select 'Yes, clear page information' to clear information on this page. Select 'Cancel' to go back to the questionnaire.' At the bottom, there are two buttons: 'Cancel' and 'Yes, clear page Information'. The 'Yes, clear page Information' button is highlighted with a red box.

- ! Pages that do not contain Validated Assessment Tool triggering questions will only give you the options to **Clear Page** or **Cancel**. On pages that contain Validated Assessment Tools trigger questions, you also have the option to select **Clear All**.

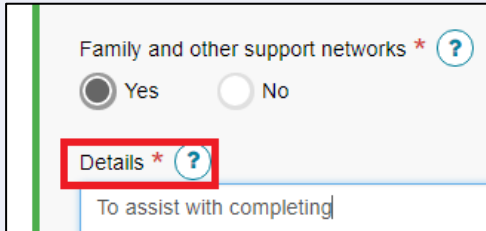
When you select **Clear Page**, the system shows a progress indicator while it removes the information. Clearing the page also removes any selected check boxes  that triggers the display of a Validated Assessment Tool.

To clear information entered in a Validated Assessment Tool, either select **Clear All**, or go to the page where the tool is located and select **Clear Page Information**.

3. Visual indicators help you complete the form. If you have not answered a required question, a red line appears beside the field. Once you answer the required question, this line changes to green.

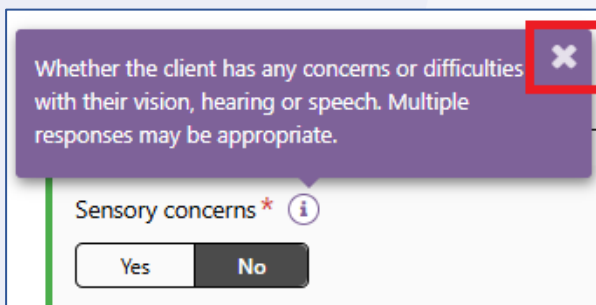


4. Some answers require you to provide additional information. When this happens, a red asterisk (*) appears next to the relevant field to show that it is now required.



5. Some answers may trigger additional questions. Complete these questions to provide more information about the client's needs based on the response you selected.

6. Select the Information  icon next to a question to view on-screen help text. The help text remains open until you select the X to close it or open a different help text box.



7. At the bottom of each page, select both required checkboxes:

- 'I have reviewed the information on this page and I confirm that it is correct.'
- 'I have confirmed that any required goals are added to the Support Plan.'

To continue, select **Next** in the bottom-right corner of the page, or choose the next section from the navigation bar. The system automatically saves your assessment information as you move between pages.

8. When you complete all required questions on a page, marked by an **asterisk (*)** and a **red line**, a **green tick** appears next to that section in the navigation bar to show it is complete.

Clinical attendance (for non-clinical assessors)

The IAT uses threshold questions to identify when a client may need a more detailed clinical or **comprehensive assessment**. These questions are highlighted with a **blue banner**.

Your answer to a threshold question may trigger additional clinical questions.

For example, if you answer No to the question "Is the client managing urinary incontinence issues?", the system displays additional questions that require input from a clinical assessor.

Toileting – Bladder *

Occasional accident (max. once per 24 hours) ☐ Add as Functional Need

Is the client managing urinary incontinence issue? *

Yes No

This section of IAT must be completed under your organisation's clinical governance

Is the client able/willing to complete the Revised Urinary Incontinence Scale? *

Yes No

Non-clinical assessors can only complete these questions through the **clinical attendance process**, in line with their assessment organisation's clinical governance framework.

To complete these questions:

1. Select **Yes** to confirm that you are completing this section of the IAT under your organisation's clinical governance arrangements.
2. Enter or select the name of the **supervising clinical assessor** who provided the clinical attendance.
3. Select **SAVE DETAILS**.

Clinical Declaration and Supervisor details

I confirm that I am completing this section of the IAT under my organisation's clinical governance *

Yes No

Please select the supervising assessor

Start to type...

After you save the details, the supervising clinical assessor's information appears in the IAT. You can then continue completing the assessment with clinical supervision.

Clinical Declaration and Supervisor details

Clinical Declaration: Provided Supervising Assessor: Name SURNAME

This section of IAT must be completed under your organisation's clinical governance

Is the client able/willing to complete the Revised Urinary Incontinence Scale? *

Yes No

Health Conditions

In the **Medical and Medications** section, add the client's health conditions by searching for the condition name or code.

Save Assessment

Triage
Assessment Details
Reason for Assessment
Carer Profile
Medical and Medications
Function
Physical, Personal Health & Frailty
Social
Cognition
Behaviour
Psychological
Home & Personal Safety
Financial or Legal
Support Considerations

Medical and Medications
Clear Page Information

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

Medical

Client in receipt of medical treatments ⓘ

☐ Drip infusion in vein
☐ Home Dialysis (peritoneal or haemodialysis)
☐ Centre/hospital Dialysis

☐ Stoma care
☐ Oxygen Therapy
☐ Use of Ventilator

☐ Use of Nebuliser
☐ Tracheostomy care
☐ Nursing care for pain

☐ Enteral Feeding Supplement - Bolus
☐ Enteral Feeding Supplement - Non-bolus
☐ Parenteral feeding (intra-venous hyperalimentation)

☐ Care for chronic ulcer
☐ Urethral catheter

Health condition(s) ⓘ
☐ Add as Other Consideration

Health Condition * ⓘ	Health Condition Description * ⓘ	Diagnosis Status ⓘ	Primary Health Condition ⓘ
			Primary Health Condition

+ Add Health Condition

You can add up to **10 health conditions** for each assessment.

Start typing in the search field and select the appropriate health condition from the list of options.

Health condition(s) ⓘ
☐ Add as Other Consideration

Health Condition * ⓘ	Health Condition Description * ⓘ	Diagnosis Status ⓘ	Primary Health Condition ⓘ
asth 1004 - Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis & sinusitis, chronic diseases of tonsils & adenoids)			Primary Health Condition

+ Add Health Condition

After selecting a condition, update the description if needed to reflect the client's circumstances and choose the relevant **Diagnosis Status**.

Health condition(s)  ☐ Add as Other Consideration

Health Condition * 	Health Condition Description *	Diagnosis Status * 	Primary Health Condition * 
1004	Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis & sinusitis, chronic diseases of tonsils & adenoids)	- Client reported - GP confirmed - Hospital confirmed - Other health practitioner confirmed	Primary Health Condition 

To add another health condition, select **+ Add Health Condition**. To remove a health condition, select the **bin** icon.

You must also identify the client's **Primary Health Condition**. You can choose to include health conditions as Other Considerations in the client's Support Plan.

Health condition(s)  ☒ Add as Other Consideration

Health Condition * 	Health Condition Description *	Diagnosis Status * 	Primary Health Condition * 
1004	Other diseases of upper respiratory tract (includes respiratory allergies (excluding allergic asthma), chronic rhinitis & sinusitis, chronic diseases of tonsils & adenoids)	GP confirmed	Primary Health Condition 
1307	Osteoarthritis	Hospital confirmed	Primary Health Condition 

+ Add Health Condition

Adding Identified Needs

As you complete the assessment, you can add information to the client's Support Plan by selecting:

- **Add as Functional Need**
- **Add as Complexity Indicator**
- **Add as Other Consideration**
- **Add as Recommendation.**

When available, these options appear as checkboxes on the right-hand side of the relevant IAT questions.

A list of four checkboxes, all of which are checked. The options are:

- ☒ Add as recommendation
- ☒ Add as Other Consideration
- ☒ Add as Functional Need
- ☒ Add as Complexity Indicator

Add As Functional Need example

Get to places out of walking distance * ⓘ

Without help **With some help** Completely unable

Who helps? *

☒ Informal carer(s) ☐ Aged care service provider(s) ☐ Other

☒ Add as Functional Need

Add As Other Consideration and Add as Recommendation examples

Home safety equipment client has

☒ Smoke alarm(s)

☒ Personal alarm

☐ Personal emergency plan

☐ Other technology

☒ Add as Other Consideration

☒ Add as Recommendation

☒ Add as Recommendation

☐ Add as Recommendation

In some cases, the system automatically selects these checkboxes based on the answers you enter.

For example, if a client has an assistance dog, is eligible for and able to access the Physical Assistance Dogs Program, and the dog meets the HealthDirect definition of an assistance dog; the system automatically adds **Assistive Technology – Assistance Dog** as an **Other Consideration** in the Support Plan.

Does the client have any vision, hearing, speech or somato related concerns or difficulties? *

Vision *

☒ Low vision ☐ Monocular blindness ☐ Binocular blindness

Does the client have an assistance dog? *

☒ Yes ☐ No

Is the client eligible for and able to access the Federal Government funded Physical Assistance Dogs Program? *

☐ Yes ☒ No

Does the client's assistance dog meet the definition of an assistance dog used by Health Direct? *

☒ Yes ☐ No

☒ Add as Other Consideration

You can also add **Assistive Technology** and **Home Modifications** as **Other Considerations** in the Support Plan.

The system displays this option at the end of seven assessment topics:

- Medications
- Function
- Physical Personal Health and Frailty
- Social
- Cognition
- Psychological
- Home and Personal Safety.

Use this option to identify whether the client may need funding for assistive technology or home modifications.

When you select this option, the **Add as Other Consideration** checkbox is automatically selected and cannot be changed.

In relation to function, this client would benefit from funding for:

☒ Assistive technology ☐ Home modifications

☒ Add as Other Consideration

When you select these checkboxes, the information appears in the relevant sections of the client's **Support Plan**.

Functional Needs, **Complexity Indicators**, and **Other Considerations** appear on the Other Considerations tab and in the Assessment Summary.

Recommendations appear on the **Goals & Recommendations** tab.

! Remember to add any Assistive technology and Home modifications considerations to the client's support plan. Refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#).

Support plan and services

COMPREHENSIVE ASSESSMENT DD MM YYYY PRINT COPY OF SUPPORT PLAN

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

Assessment summary

EDIT

Introduction
Title Name SURNAME, age XX, contacted My Aged Care and has been referred for assessment as Reduce rate of decline in level of function and/or independence. An assessment occurred Face-to-face DD Month Year in Client's home. Assessment information was provided by client.

Situation
[Add comments relating to current social situation].
Name experience 0000 - No health conditions present.
[Add comments relating to medical issues].

Background
Name lives with no specified in Independent living within a retirement village.
[Add comments relating to social history].
[Add comments relating to informal support].

Assessment
Data goes here about assessment.
[Add comments relating to function/mobility].
Bruce experiences: Manageable medical issues and mobility.

Recommendation
Following the assessment Care would benefit from [add outcomes]

Functional needs

Transport
Light Housework
Shopping
Meals preparation

Other considerations

Assistive technology consideration - Function
Home modifications consideration - Function
Assistive technology consideration - Physical personal health and frailty
Home modifications - Physical personal health and frailty
AT-Ongoing consideration - Assistance Dog

Complexity indicators

PRE-POPULATE FROM ASSESSMENT EDIT

Viewing and adding carers in the assessment

You can view, add, and update carer information directly from the assessment without returning to the client record.

1. In the navigation menu, select **Carer Profile**, then select **View/Add Carers**.

Name SURNAME

Gender, XX years old, DD Month Year, ACXXXXXX01
XX Street Name, SUBURB, STATE, POSTCODE

VIEW/ADD CARERS

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Carer Profile

Clear Page Information

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

How many people excluding the client live in the same household as the client? *

2. A pop-up window opens and displays any carers already linked to the client. To add a new carer, select **Add a Carer**.

Carers

Current carers

Add a carer

ADD A CARER

SAVE

3. Enter the person's first and last name, then select **Search**. To search using more information, select **Show More Search Fields** and enter the available details.

Find a carer

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

First name *

Last name *

Date of birth
(e.g. dd/mm/yyyy)

SHOW MORE SEARCH FIELDS

SEARCH CANCEL

4. If the person already has a record, they appear in the search results. Select the radio button next to their name to open additional fields, including client consent, carer consent, and the carer's relationship to the client. Then select **Add**.

Find a carer

Date of birth
(e.g. dd/mm/yyyy)

SHOW MORE SEARCH FIELDS

1 matching results

☒ Name SURNAME

Client Consents to Relationship*

☒ Yes
☐ No

Carer Consents to Relationship*

☒ Yes
☐ No

What is the relationship of the user to the client? *

Neighbour

ADD

ADD A CARER

SEARCH CANCEL

5. A confirmation message appears to let you know that you have successfully added a carer.

Select **Save** to save your changes.

Carers

✓ You have successfully added a carer.

Current carers

Name SURNAME

Carer added DD Month Year

XX Street Name, SUBURB, STATE, POSTCODE

Lives with client*

☐ Yes

☒ No

Add a carer

ADD A CARER

SAVE

If there are no results, or you want to add a different carer, select **ADD A CARER**.

Find a carer

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

First name*
Name

Last name*
SURNAME

Date of birth
(e.g. dd/mm/yyyy)

SHOW MORE SEARCH FIELDS

1 matching results

☐ Name SURNAME

ADD

ADD A CARER

SEARCH CANCEL

6. Enter all required information about the carer, including confirmation that both the client and the carer have consented to the relationship. Then select **Save**.

At this stage, consent is only required to create the client-carer relationship in the My Aged Care system. Once you create the relationship, the carer appears in the client's support network and becomes available to add to the client's support plan later.

You must obtain consent for any future changes to the client-carer relationship.

For information about recording consent for referrals or call-backs from the [Carer Gateway](#) and/or National Dementia Helpline, go to [Assessor Portal User Guide 2 – Registering support people and adding relationships](#).

Add a person

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

First name: *
Name

Last name: *
SURNAME

Date of birth:
(e.g. dd/mm/yyyy)

Gender: *
Gender

Lives with client*
☐ Yes
☒ No

Client Consents to Relationship*
☒ Yes
☐ No

Carer Consents to Relationship*
☒ Yes
☐ No

What is the relationship of the user to the client? *
 Friend

SAVE CANCEL

7. A confirmation message appears to confirm that you have successfully added a carer.
Select **Save** to save your changes.

Carers

✓ You have successfully added a carer.

Current carers

Name SURNAME
 Carer, added DD Month Year
 XX Street Name, SUBURB, STATE, POSTCODE
 Lives with client*
☐ Yes
☒ No

Name SURNAME
 Carer, added DD Month Year
 Lives with client*
☒ Yes
☐ No

Add a carer
 ADD A CARER

SAVE

Adding a Sensitive Attachment in the assessment

Assessors can add sensitive client information as part of the assessment.

1. To download the **Sensitive Attachment Form**, go to the **Support Considerations** section of the IAT and select **Download Sensitive Attachment Form**.

Name SURNAME

Gender, XX years old, DD Month Year, ACXXXXXX01
XX Street Name, SUBURB, STATE, POSTCODE

[DOWNLOAD SENSITIVE ATTACHMENT FORM](#) [UPLOAD SENSITIVE ATTACHMENT FORM](#)

Financial or Legal ☒

Support Considerations ☒

Any evidence that the client is self-neglecting of personal care, nutrition or safety? ☐ Add

Yes No

Risk client may cause harm to themselves or others ☐ Add

Yes No

You can also download the form from the **Forms** tab in the **Reports & Documents** section of the assessor portal.

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

Assessor Portal

My Dashboard Find a client Assessment referrals Review requests Assessments Reviews Delegate decisions Organisation administration Residential Funding Referrals Find a service provider **Reports and documents** Aged Care Assessor app

Reports and documents

Reports **Forms** Links

Forms

- Self-Service Form - Abbey Pain Scale [pdf 221.46KB]
- Self-Service Form - Alcohol Use Disorders Identification Test [pdf 287.27KB]
- Self-Service Form - Application for Care - October 2020 [pdf 354.04KB]
- Self-Service Form - Barthel Index of Activities of Daily Living [pdf 216.67KB]
- Self-Service Form - Brief Pain Inventory [pdf 256.86KB]
- Self-Service Form - Caregiver Strain Index [pdf 148.48KB]
- Self-Service Form - Client Record Details [pdf 364.25KB]
- Self-Service Form - NSAF Comprehensive Assessment and Support Plan 20221027 [PDF 329.55KB]
- Self-Service Form - Geriatric Depression Scale [pdf 217.58KB]
- Self-Service Form - Home Support Assessment and Support Plan - October 2018 [pdf 484.48KB]
- Self-Service Form - Informant Questionnaire on Cognitive Decline in the Elderly (IQ CODE) [pdf 219.08KB]
- Self-Service Form - my-aged-care-assessment-iat-offline-form-v1 [pdf 1.28MB]
- Self-Service Form - K-10 [pdf 942.84KB]
- Self-Service Form - KICA-COG images [pdf 539.52KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - ADL [PDF 148.59KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Carer [pdf 695.20KB]
- Self-Service Form - Kimberley Indigenous Cognitive Assessment - Cognitive Assessment (KICA-COG) [pdf 895.96KB]
- Downloads - Mini Nutritional Assessment [pdf 81.38KB]
- Self-Service Form - Modified Caregiver Strain Index [pdf 216.96KB]
- Self-Service Form - My Aged Care Assessment Consent Form v2.1 [pdf 316.19KB]
- Template - Template Notice of priority for home care service - not vary v1.0 [rtf 10.27KB]
- Template - Template Notice of priority for home care service - vary v1.0 [rtf 10.73KB]
- Self-Service Form - Offline Approval Form Vary Time Limitation v2.0 - 20220523 [pdf 359.29KB]
- Self-Service Form - Offline Approval Form v2.0 20221027 [PDF 674.00KB]
- Self-Service Form - Older Americans Resources and Services (OARS) - Instrumental Activities ... [pdf 942.40KB]
- Self-Service Form - Oral Health Assessment Tool [pdf 218.42KB]
- Self-Service Form - Residents Verbal Brief Pain Inventory [pdf 248.45KB]
- Self-Service Form - Revised Faecal Incontinence Scale [pdf 217.63KB]
- Self-Service Form - Revised Urinary Incontinence Scale [pdf 148.13KB]
- Self-Service Form - Rowland Universal Dementia Assessment Scale [pdf 981.66KB]
- Downloads - Sensitive Attachment v1.0 [docx 62.40KB]**
- Self-Service Form - South Australian Oral Health Referral Pad [pdf 217.14KB]
- Self-Service Form - Standardised Mini-Mental State Examination (SMMSE) [pdf 290.84KB]

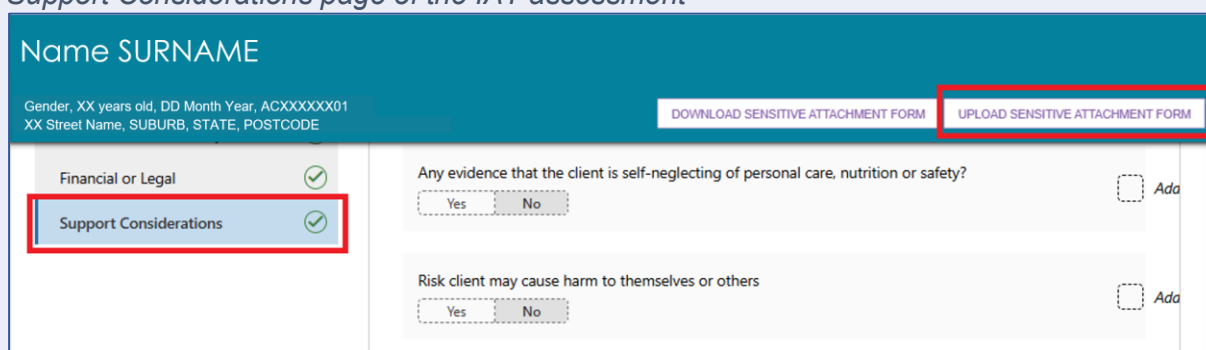
Once downloaded, the **Sensitive Attachment** form will display.



Client Name:	
Aged Care ID:	
Concern with financial situation	
☐ Yes	☐ No
Details	
Concern with living arrangements	
☐ Yes	☐ No
Details	

- Complete the form, then upload it by selecting **Upload Sensitive Attachment Form** on the **Support Considerations** page. You can also upload it from the **Attachments** page by selecting **Add an Attachment**.

Support Considerations page of the IAT assessment



Name SURNAME

Gender, XX years old, DD Month Year, ACXXXXXX01
XX Street Name, SUBURB, STATE, POSTCODE

DOWNLOAD SENSITIVE ATTACHMENT FORM **UPLOAD SENSITIVE ATTACHMENT FORM**

Financial or Legal ☒

Support Considerations ☒

Any evidence that the client is self-neglecting of personal care, nutrition or safety?

☐ Yes ☐ No

Risk client may cause harm to themselves or others

☐ Yes ☐ No

Attachments Page



Attachments

Client summary Client details Support Network Approvals Plans **Attachments** Services

Attachments

ADD AN ATTACHMENT

Assessment Attachments Other Attachments Correspondence

- The **Upload sensitive attachment** pop up, or the **Add an attachment** pop up, appears. Enter the required details for the attachment.

If you are using **Add An Attachment**, select either **Sensitive Attachment** or **Sensitive Client Status** as the attachment type.

Select **Upload** to submit the file.

Upload sensitive attachment pop up

Upload sensitive attachment



Please note: Some attachments will be viewable by other people with authorised access to this client record. Please refer to your portal guide for details.

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

You can upload files up to 5 MB to this record. The following file types are accepted:
.jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .txt *

CHOOSE FILE

No file chosen

Name of the attachment: *

Please provide a short description about the contents of the attachment, e.g. assessment date and time

0 / 250

UPLOAD

CANCEL

Add an attachment pop up with the Type Of Attachment drop down expanded

Add an attachment

i Please note: Some attachments will be viewable by other people with authorised access to this client record. Please refer to your portal guide for details.

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

You can upload files up to 5 MB to this record. The following file types are accepted:
.jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .txt *

No file chosen

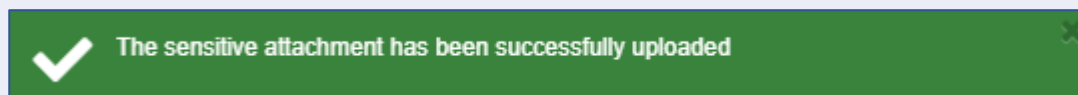
Name of the attachment: *
(150 characters)

Please provide a short description about the contents of the attachment, e
(250 characters)

Type of attachment *
Select one

- HM prescription
- HM quote
- Inbound referral information
- Ineligible for Assessment Ltr
- Legal documentation
- Letter by Medical Pract.
- Medication Summary
- Non-Approval Letter to Client
- Occupational Therapy Plan
- Offline Approval Form
- Offline Notes
- Prior Assessment
- Prior Support Plan
- Relevant Medical Summary
- Sensitive Attachment**
- Sensitive client status
- Specific Service Requirements
- Support Plan - External
- Wound Care Plan
- Other

4. Once successfully uploaded, a green banner will display at the bottom of the screen.



5. The sensitive attachment appears in the **Other Attachments** tab on the client's **Attachments** page. The client's personal details section also displays a **Sensitive Attachment** indicator.

If you do not want the attachment and its details to appear on the Attachments page, select **Hide from View**.

Name SURNAME
Gender, XX years old, DD Month Year, ACXXXXXX01
XX Street Name, SUBURB, STATE, POSTCODE
Sensitive attachment
Primary contact: Name SURNAME (Supporter, Spouse/Partner) - 02 XXXX XXXX
[View support network](#)

Attachments
REFER THIS CLIENT FOR ASSESSMENT VIEW CLIENT REPORT

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

Residential Funding Classifications

Attachments
ADD AN ATTACHMENT

Assessment Attachments **Other Attachments** Correspondence

Sensitive Attachment DD Month Year
Sensitive attachment for Title Name.docx [62.41KB]
Sensitive information related to assessment on 1/1/2025
HIDE FROM VIEW

- ! If you add a **Sensitive Attachment** during the assessment, record this on the **Support Considerations** page.

Sensitive attachments are only visible to My Aged Care contact centre staff and assessors. Clients cannot view them through their My Aged Care online account, and service providers cannot access them directly.

When a service provider accepts the client's referral, the system notifies them that sensitive information is available. The provider can then contact the client's assessor or the My Aged Care contact centre to request access to the information.

Support Considerations

Attachment * ?
☒ Yes ☐ No

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

Navigating the Validated Assessment Tools

1. Use **Validated Assessment Tools (VATs)** to help assess a client's needs. The system includes a range of VATs, with some built directly into the Integrated Assessment Tool (IAT) and others available as optional tools when needed. For example, the Duke Social Support Index is built into the **Social** section of the IAT.

Duke Social Support Index - Social Interaction Subscale

Other than members of your family, how many persons in your local area do you feel you can depend on or feel very close to?

None 1-2 people More than 2 people

How many times during the past week did you spend time with someone who does not live with you, that is, you went to see them or they came to visit you or you went out together?

None Once Twice Three times Four times Five times Six times Seven or more times

How many times did you talk or communicate to someone, friends, relatives or others on the telephone, mobile (e.g. text message) or social media (e.g. Facebook, snapchat, Instagram) in the past week (either they contacted you or you contacted them)?

None Once Twice Three times Four times Five times Six times Seven or more times

About how often did you go to meetings of clubs, religious meetings or other groups that you belong to in the past week?

None Once Twice Three times Four times Five times Six times Seven or more times

Total score Total score cannot be calculated until all questions have been answered

Landerman alternative models stress buffering 1989

2. Some **Validated Assessment Tools (VATs)** only appear when the client's responses indicate they may be relevant and the client agrees to complete them.

For example, the Revised Urinary Incontinence Scale appears when the client's responses indicate urinary incontinence and the client is willing and able to complete the tool.

Is the client able/willing to complete the Revised Urinary Incontinence Scale? * ⓘ

Yes No

Revised Urinary Incontinence Scale (RUIS) ⓘ

Urine leakage related to the feeling of urgency

Not at all Slightly Moderately Greatly

Urine leakage related to physical activity, coughing or sneezing

Not at all Slightly Moderately Greatly

Small amounts of urine leakage (drops)

Not at all Slightly Moderately Greatly

How often do you experience urine leakage?

Never Less than once a month A few times a month A few times a week

How much time do you lose each time?

None Drops Small splashes More

Total score ⓘ Total score cannot be calculated until all questions have been answered

Sanconi J, Hawthorne G, Fleming G, Owen E and Marosszeky N (2015) Technical Manual and Instructions: Revised incontinence and Patient Satisfaction Tools, Version 2, Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong. Used by permission.

3. The system automatically calculates the total score for these **Validated Assessment Tools (VATs)** based on the client's responses.

Your assessment organisation can also choose to use other validated assessment tools that are not included in the IAT. If you use these tools, upload the completed forms as attachments to the client's record.

You can download blank copies of these tools from the **Reports & Documents** section of the assessor portal.

4. If you need to remove responses from a Validated Assessment Tool (VAT), select the **eraser** icon to clear the tool's responses.

Other than members of your family, how many persons in your local area do you feel you can depend on or feel very close to?

None

1-2 people

More than 2 people



- ! Assessors must complete all required screening tools in the **Cognition** section.

If the client does not have a confirmed dementia diagnosis and does not complete either **Step 1 GP-Cog** or **Step 2 GP-Cog**, you must record the reason why the client did not complete the cognitive screening tool.

Cognition

Clear Page Information

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

Does client have a confirmed dementia diagnosis from a geriatrician or neurologist? *

Yes No

Is it suitable the client complete the Step 1 GP Cog? *

Yes No

Is there an informant available to complete GPCog - Step 2? *

Yes No

Please provide a reason for the client not completing the cognitive screening tool *

Client displays cognitive issues but declines to complete cognitive questions	Client does not display cognitive issues but declines to complete cognitive questions	Unsure if Client displays cognitive issues but declines to complete cognitive questions
---	---	---

Modified de Morton Mobility Index (DEMMI) and Residential Respite Care (Clinical assessor)

The IAT includes a validated assessment tool called the Modified de Morton Mobility Index (DEMMI-Modified).

Only clinical assessors can complete this tool, and they must do so during a face-to-face assessment when assessing a client's needs for residential respite services.

Non-clinical assessors must not complete the DEMMI-Modified, including under clinical attendance arrangements.

The information collected through the DEMMI-Modified contributes to the Australian National Aged Care Classification (AN-ACC).

1. In the **Function** section of the IAT, answer the question: **Are you likely to recommend residential respite care?** Select **Yes** or **No**.

If you select **Yes**, the system asks a second question: **De Morton Mobility Index (DEMMI)?** Select **Yes** or **No**.

Are you likely to recommend residential respite care? ⓘ

Yes No ⓘ

De Morton Mobility Index (DEMMI) - Modified ⓘ

Yes No

2. If you answer **Yes** to the above question, you must complete the DEMMI-Modified assessment.

The DEMMI-Modified will appear in the navigation bar below the **Function** section.

Save Assessment

Triage ⓘ

Assessment Details ✓

Reason for Assessment ✓

Carer Profile ✓

Medical and Medications ✓

Function

De Morton Mobility Index (DEMMI) Modified ✓

Physical, Personal Health & Frailty

Social

De Morton Mobility Index (DEMMI) - Modified ⓘ Clear Page Information

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

General Description
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
Capability – take account of physical function, cognition and behaviour, motivation, and organisational ability
If differences in function occur in different environments or times of the day (i.e. day/night), record the lower score
Preferably base this tool on direct observation, unless there is a falls risk or it causes the resident distress
Rate with current aids and appliances in place

Scoring definitions
Minimal assistance – "hands-on" physical but minimal assistance, primarily to guide movement
Supervision – another person monitors the activity without providing hands-on assistance. May include verbal prompting
Independent – the presence of another person is not considered necessary for safe mobility

3. Complete the four sections of the DEMMI-Modified by selecting the option that best reflects the client's mobility.
 - **Bed**
 - **Chair**
 - **Static Balance (No Gait Aid)**
 - **Walking.**

Bed

Bridge 

Unable Able

Roll onto side 

Unable Able

Lying to sitting 

Unable Minimal assistance Supervision Independent

4. Select the Help icon  to reveal help text.

Bridge 

Person is lying supine and is asked to bend their knees and lift their bottom clear of the bed.

Bridge 

Unable Able

5. Select the Eraser icon  to clear your answer.

Sit unsupported in chair 

Unable 10 seconds



6. After completing all required sections, confirm that the information on the page is correct and that you have added any required goals to the **Support Plan**. Then select **Next**.

Walking independence 

Unable Minimal assistance **Supervision** Independent with gait aid 

Independent without gait aid

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

! Please confirm you have completed the clients' goals before you finalise the IAT. Once you finalise the IAT, the IAT outcome and any recommendation prompts will be generated.

Before you confirm, please select 'Save Questionnaire And Continue to Support Plan' and in 'Goals & Recommendations' take the following actions:

- Add any goals that you may have identified are required for the client.
- Review any pre-existing goals.

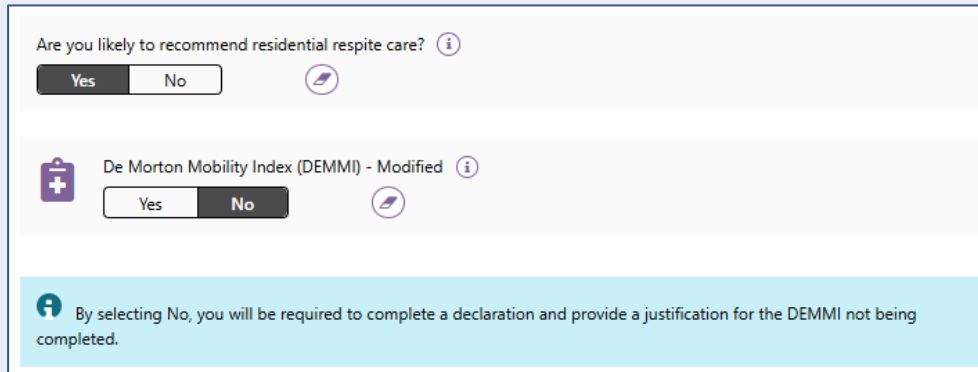
If you have identified there are no goals required for the client, you can confirm and finalise the IAT.

☒ I have confirmed that any required goals are added to the Support Plan

Next

7. Continue completing the assessment and submit your recommendation for **residential respite care** for delegate approval.

If you recommend residential respite care without completing the **DEMMI-Modified**, the system prompts you to select a declaration checkbox and to enter a reason for not completing the DEMMI-Modified.

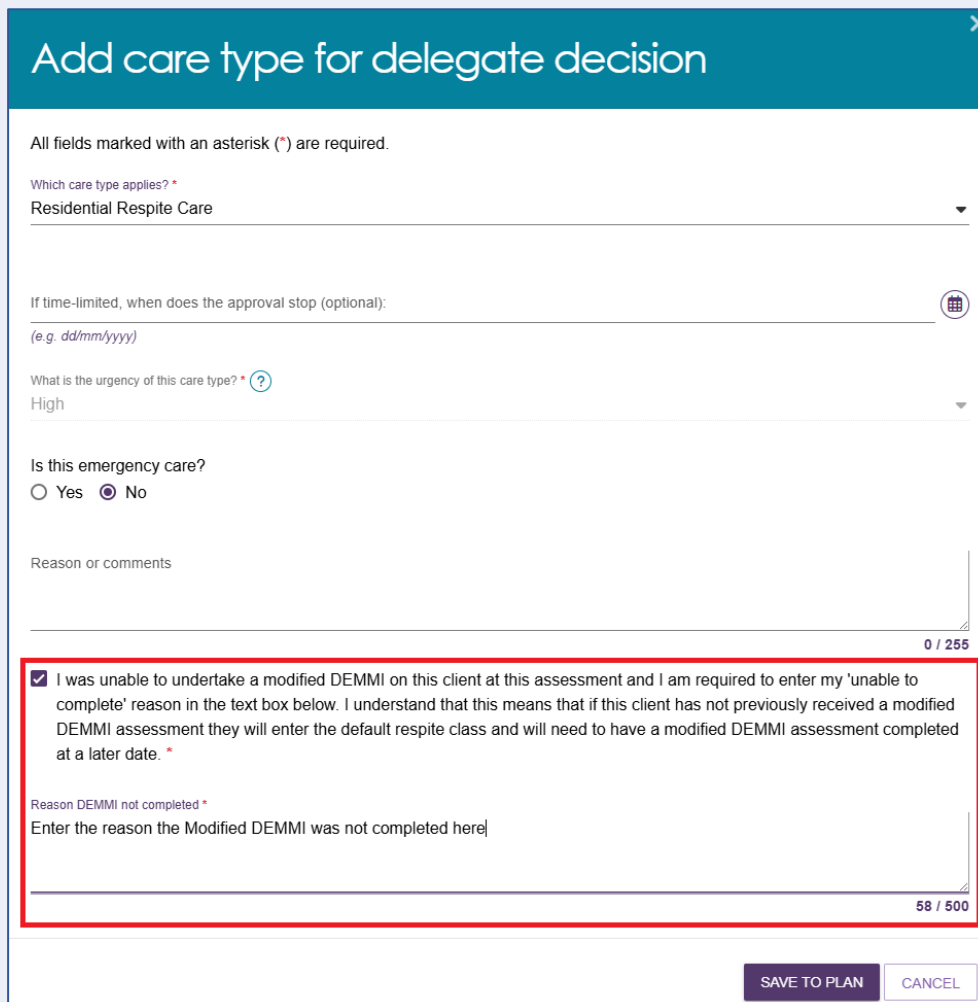


Are you likely to recommend residential respite care? ⓘ

De Morton Mobility Index (DEMMI) - Modified ⓘ

By selecting No, you will be required to complete a declaration and provide a justification for the DEMMI not being completed.

The **Add Care Type for Delegate Decision** pop-up displays the declaration checkbox and the field where you enter the reason for not completing the DEMMI-Modified.



Add care type for delegate decision ✕

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

Which care type applies? *

Residential Respite Care

If time-limited, when does the approval stop (optional): ⓘ

(e.g. dd/mm/yyyy)

What is the urgency of this care type? * ⓘ

High

Is this emergency care?

☐ Yes ☒ No

Reason or comments

0 / 255

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

Reason DEMMI not completed *

Enter the reason the Modified DEMMI was not completed here

58 / 500

Saving an assessment

1. If you are not ready to finish the assessment, select **Save Assessment** to save your progress.

Name SURNAME

Gender, XX years old, DD Month Year, ACXXXXXX01
XX Street Name, SUBURB, STATE, POSTCODE

Save Assessment

Triage

Assessment Details

Assessment Details

Clear Page Information

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

2. The system displays a **green confirmation message** to let you know the assessment has been saved successfully.

Name SURNAME

Gender, XX years old, DD Month Year, ACXXXXXX01
XX Street Name, SUBURB, STATE, POSTCODE

Save Assessment

Triage

Assessment Details

Reason for Assessment

Carer Profile

Medical and Medications

Function

Physical, Personal Health & Frailty

Reason for Assessment

Clear Page Information

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

What is the key circumstance that has triggered client/supporter seeking assessment for aged care services? * ⓘ

☐ Referral from a health professional
 ☐ Hospital discharge
 ☐ Fall(s)

☐ Medical condition(s)
 ☒ Difficulties with activities of daily living
 ☐ Change in caring arrangements

Assessment successfully saved

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Australian Government
Department of Health and Aged Care

myagedcare

3. You can return and continue the assessment at a later time. If you want to work on the support plan before finishing the assessment, select **Save Questionnaire and Continue to Support Plan** at the bottom of the page.

FINALISE IAT AND GO TO SUPPORT PLAN

SAVE QUESTIONNAIRE AND CONTINUE TO SUPPORT PLAN

CANCEL ASSESSMENT - NO FURTHER ACTION REQUIRED

4. The assessment appears in the **Assessment In Progress** section of your **Current Assessments** tab.

To help prevent data loss, the system also saves your work automatically at regular intervals, including when the portal is idle.

Current assessments Currently viewing ABC Outlet

Current assessments Recent assessments

Filter by

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

Current sort order is Assessment Priority 1 to 42 out of 42 matching results

Assessment In Progress

Name SURNAME	Name SURNAME	Name SURNAME
Aged care user ID: ACXXXXXX01 Date accepted: DD Month Year Completed Support Plan due by: DD Month Year	SUBURB, STATE, POSTCODE Aged care user ID: ACXXXXXX01 Date accepted: DD Month Year Completed Support Plan due by: DD Month Year	SUBURB, STATE, POSTCODE Aged care user ID: ACXXXXXX01 Date accepted: DD Month Year Completed Support Plan due by: DD Month Year
Comprehensive 224 days overdue	Comprehensive 175 days overdue	Comprehensive Due in 2 days
Assessment In Progress High	Assessment In Progress High	Assessment In Progress Low

Finalising the IAT

- Before you finalise the IAT, make sure you have recorded and completed the client's goals.

For more information about goals, refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#)

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

! Please confirm you have completed the clients' goals before you finalise the IAT.
Once you finalise the IAT, the IAT outcome and any recommendation prompts will be generated.

Before you confirm, please select 'Save Questionnaire And Continue to Support Plan' and in 'Goals & Recommendations' take the following actions:

- Add any goals that you may have identified are required for the client.
- Review any pre-existing goals.

If you have identified there are no goals required for the client, you can confirm and finalise the IAT.

☒ I have confirmed that any required goals are added to the Support Plan.*

Next

- When you have completed all required assessment questions, select **Finalise IAT and Go to Support Plan** at the bottom of the assessment page.

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

3. The system then displays a pop-up asking whether the client consents to sharing their support plan through **My Health Record**. The pop-up includes:
- information about sharing the support plan
 - guidance on when and how to obtain consent, including whether the client has the capacity to provide informed consent
 - a consent script to read to the client
 - options to record consent for service referrals and consent to share the support plan through My Health Record.

! A client can withdraw their consent at any time by calling the **My Aged Care Contact Centre** on **1800 200 422**.

Assessors can also update a client's consent through the **Client Details** tab in the client record.

For more information regarding this please refer to the [My Aged Care – Assessor Portal User Guide 4 – Navigating and updating the client record](#).

Consent for Service Referrals and share Support Plan with My Health Record

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

Information

Informed consent is necessary to meet requirements of both the *Privacy Act 1988* with respect to the collection, use and disclosure of personal and sensitive information and the use and disclosure of protected information under *Chapter 7, Part 2 of the Aged Care Act 2024*.

Prior to discussing referral for services, the assessors must read out the script to the client and record the client's consent to be referred for services. Assessors must also seek the clients' consent to have their support plan uploaded to their My Health Record. The client or their supporter or guardian can also withdraw these consents at any time by contacting My Aged Care (www.myagedcare.gov.au/contact-us).

The script is to be used as a guide to assist the client in providing informed consent and can be tailored to ensure that the information is understood by the client (note that you **must** bring the contents of the privacy notice, including the web address to the client's attention). If the assessor significantly deviates from the scripts, this should be noted in the client's My Aged Care record.

If there is a suggestion that the client lacks capacity, obtain consent from the client's registered supporter or guardian in My Aged Care.

When and how to seek consent?

Assessors must seek and gain informed consent from the client (or supporter or guardian) prior to referring clients to a service provider.

The assessor can also use the 'Notes' section in the client's record to:

- record any detail or the circumstances regarding the handling of a client's personal information) and
- record any instructions relating to the assessor's conversation with the client (or their supporter or guardian) with respect to informed consent.

Does client have capacity to give informed consent?

Prior to obtaining consent, the assessor must determine whether the client has the capacity to understand and communicate their consent by determining if:

- The client can provide their informed consent independently,
- The client can provide their informed consent with the assistance of their supporter or guardian,
- The client lacks capacity and requires their guardian to provide consent on their behalf (this consent cannot be provided by their supporter).

If a supporter or guardian (includes other persons in a similar position to a guardian as defined under subsection 28(2) of the Aged Care Act 2024) is required, they must be registered as such in My Aged Care prior to obtaining the client's consent.

For more information, please see the consent section of [My Aged Care Assessment Manual](#)

Script to be read.

If you are eligible for an aged care service or services, the assessor will refer you to one or more service providers to arrange the kind of services that you need. In giving your consent for the service referrals, you understand that:

- Your service referrals will contain personal information about your assessed care needs and circumstances that have been obtained from your My Aged Care client record, including your name, address, contact details and care needs.
- Information about your service referrals will be recorded in your My Aged Care client record and will be used and disclosed by service providers and the department in the course of providing aged care services to you.
- The service providers will use the referral information to decide if they can offer you the services.
- The service referral may also be recorded in the service providers' IT systems for the purposes of determining whether they can provide you with the relevant services and providing those services.
- Service providers may share your personal information with other organisations to manage the support you need, for example, the Department of Health and Aged Care, aged care or health providers, Services Australia and state and territory services.
- Services for which you are eligible are recorded in your support plan. You can consent to have your support plan uploaded to your My Health Record, if you have one. This will allow it to be viewed by yourself as well as people or entities who you have given permission to view your records, like healthcare providers and your supporter or guardian.
- As we go through the service referral process, please tell me if you do not want any of your information to be recorded. We can discuss how to manage this further.
- You can change your mind and withdraw your consent to participate in the service referral process at any time. However, this will mean the assessor cannot issue further service referrals. You will need to arrange your own aged care services.
- You are agreeing to select one (or more) of three ways to send a My Aged Care service referral to the provider.

1. **Referral code:** The assessor will give you a referral code/s to take to your chosen provider. The provider will enter

Script to be read.

If you are eligible for an aged care service or services, the assessor will refer you to one or more service providers to arrange the kind of services that you need. In giving your consent for the service referrals, you understand that:

- Your service referrals will contain personal information about your assessed care needs and circumstances that have been obtained from your My Aged Care client record, including your name, address, contact details and care needs.
 - Information about your service referrals will be recorded in your My Aged Care client record and will be used and disclosed by service providers and the department in the course of providing aged care services to you.
 - The service providers will use the referral information to decide if they can offer you the services.
 - The service referral may also be recorded in the service providers' IT systems for the purposes of determining whether they can provide you with the relevant services and providing those services.
 - Service providers may share your personal information with other organisations to manage the support you need, for example, the Department of Health and Aged Care, aged care or health providers, Services Australia and state and territory services.
 - Services for which you are eligible are recorded in your support plan. You can consent to have your support plan uploaded to your My Health Record, if you have one. This will allow it to be viewed by yourself as well as people or entities who you have given permission to view your records, like healthcare providers and your supporter or guardian.
 - As we go through the service referral process, please tell me if you do not want any of your information to be recorded. We can discuss how to manage this further.
 - You can change your mind and withdraw your consent to participate in the service referral process at any time. However, this will mean the assessor cannot issue further service referrals. You will need to arrange your own aged care services.
 - You are agreeing to select one (or more) of three ways to send a My Aged Care service referral to the provider.
1. **Referral code:** The assessor will give you a referral code/s to take to your chosen provider. The provider will enter your referral code into My Aged Care and will be able to see your information and accept your referral. [Please do not disclose your referral code to a provider until you are ready to engage their service/s as your provider of choice.]
 2. **Sequential:** The assessor will send your referral to your chosen provider/s in the order of your preference. You can limit your preference to one or more providers. If your first preference is not available, the referral is automatically sent to your next preference.
 3. **Broadcast:** The assessor will send your referral to all available providers. In agreeing to a broadcast referral, multiple providers could contact you to see if they can provide you with the service/s. If a provider accepts your referral, the other provider/s will no longer see your information.
- You can view the privacy notice which is set out at [privacy notice web address](#) as well as the My Aged Care privacy policy on the My Aged Care website at [myagedcare.gov.au](#) for more information on how we handle your personal information.
 - Do we have your consent to refer David ATTENBOROUGH to one or more service providers?
 - Do we have your consent to upload the support plan of David ATTENBOROUGH to their My Health Record?

4. After reading the **Consent to Service Referrals** information to the client or their supporter, record their decision by selecting the appropriate consent option.

Consent to service referrals

Consent obtained from *

Select one

Select one

The client

The client with support person

Consent was not given

The supporter/guardian

5. Ask the client whether they consent to sharing their **Support Plan** through **My Health Record (MHR)**, and select **Yes** or **No**. If the client gives consent, select **Yes**, record who made the decision, and then select **Continue**.

Consent to share Support Plan to My Health Record (MHR)

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

☐ No ☒ Yes

Consent decision by *

Decision made by

Decision made by

Client

Supporter Guardian

0 / 255

CONTINUE CANCEL

If the client does not give consent, select **No**.

Record who made the decision, then select the reason for not providing consent from the drop-down list.

Select **Continue** to proceed.

Consent to share Support Plan to My Health Record (MHR)

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

☒ No ☐ Yes

Consent decision by *

Please select a valid response from consent decision by

Consent denial reason *

Please select a reason for not providing the consent

Please select a reason for not providing the consent

Do not wish to disclose

Other

Privacy concerns

0 / 255

CONTINUE CANCEL

6. If a **supporter or guardian** made the consent decision, enter their **first name** before selecting **Continue**. You can also enter their **last name** and add comments if needed.

Consent decision by *

Supporter Guardian

Supporter Details

First name: *

Last name:

Comments:

0 / 255

CONTINUE CANCEL

7. Another pop-up will then display. Select **FINALISE IAT** to complete the assessment.

! Once you finalise the IAT, you cannot make any further changes unless the Assessment Delegate returns it to you for amendment. Before selecting **Finalise IAT**, review the assessment carefully and make sure all information is complete and accurate.

For information about assessments returned by a delegate for changes, refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#).

Finalise IAT and go to support plan

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

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

FINALISE IAT

TAKE ME BACK TO THE ASSESSMENT

8. A green confirmation message appears at the bottom of the screen stating: "**Consents for Service Referrals and My Health Record were updated successfully.**"



Consents for Service Referrals and My Health Record were updated successfully.

9. The system then takes you to the client's **Support Plan and Services** page to complete the support plan.

If the client agreed to share their support plan through **My Health Record**, a green confirmation message appears at the bottom of the **Support Plan and Services** page to confirm that the link was created successfully.

! If the client's My Health Record does not link successfully, the system displays an amber error message instead of a green confirmation message.

If you see the message **"Unable to share data as the system could not find an active My Health Record"**, tell the client that their support plan cannot be uploaded to My Health Record. If they need assistance, advise them to contact the My Health Record Helpline on 1800 723 471.



If you see the message **"Unable to retrieve the client's Healthcare Identifier, so we cannot match them with their My Health Record. Their Support Plan cannot be made available in their My Health Record"**, contact the My Aged Care Service Provider and Assessor Helpline on 1800 836 799.



In both cases, you can still complete the client's **Support Plan**, but the system will not upload it to **My Health Record** when you finalise it.

10. You can reopen the assessment from the Support Plan and Services page, by selecting **Go to the Assessment** on the Identified Needs tab.

Mr David ATTENBOROUGH
Male, 100 years old, 8 May 1926, AC74234634

Primary contact: David Attenborough (self)
No support relationships recorded

Support plan and services **GO TO THE ASSESSMENT** FLAG AS END-OF-LIFE HOME SUPPORT ASSESSMENT 21 MAY 2026 PRINT COPY OF SUPPORT PLAN

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

Assessment summary PRE-POPULATE FROM ASSESSMENT EDIT

Functional needs Transport

Title Name SURNAME
Gender, XX years old, DD Month Year, ACXXXXXX01

Primary contact: Name SURNAME
No support relationships recorded

Support plan and services **GO TO THE ASSESSMENT** FLAG AS END-OF-LIFE HOME SUPPORT ASSESSMENT DD Month Year PRINT COPY OF SUPPORT PLAN

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

Assessment summary PRE-POPULATE FROM ASSESSMENT EDIT

Functional needs Transport

11. You can also return to and review **Functional Needs**, **Other Considerations**, and **Complexity Indicators** by selecting the **return arrow**. Any **Assistive Technology (AT)** and **Home Modifications (HM)** identified during the assessment also appear here.

Assessment summary PRE-POPULATE FROM ASSESSMENT EDIT

Latest completed support plan review No completed review found

Functional needs Transport

Other considerations Health conditions Home safety Sensory concerns HM consideration - Home and Personal Safety Client is living in a rural or remote area.

Complexity indicators No complexity indicators found

12. The assessment outcome from the **IAT** appears in the **Goals and Recommendations** tab.

Support plan and services **GO TO THE ASSESSMENT**

Identified needs **Goals & recommendations** Decisions Manage services & referrals As

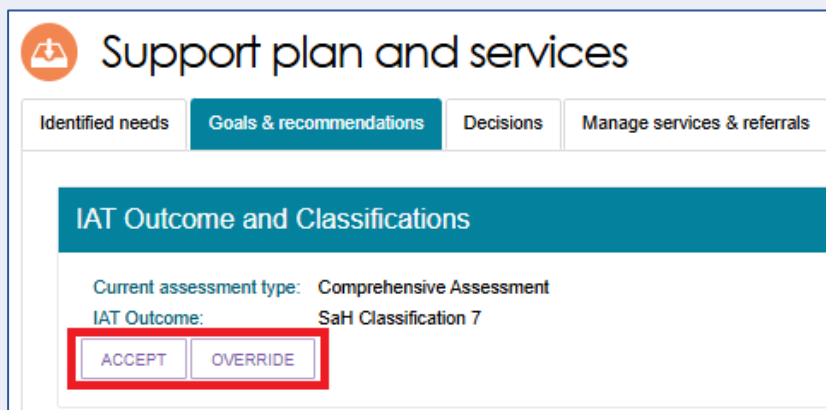
IAT Outcome and Classifications

Current assessment type: Home Support Assessment
IAT Outcome: CHSP

ACCEPT OVERRIDE

Accepting or Overriding an Assessment

When the **IAT outcome** appears, you can either **accept** the recommendation or **override** it.



Support plan and services

Identified needs | **Goals & recommendations** | Decisions | Manage services & referrals

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: SaH Classification 7

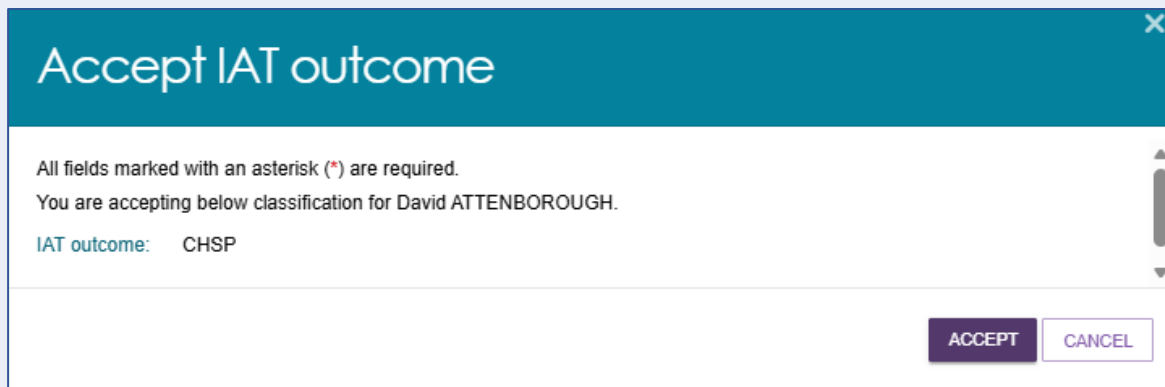
ACCEPT **OVERRIDE**

! The IAT will allow an ongoing Support at Home Classification to be overridden to a different ongoing classification level. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs.

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

Accepting IAT Outcome

To accept the recommendation, select **Accept**. The system displays a confirmation message asking you to confirm your decision. If you still want to proceed, select **Accept** again.



Accept IAT outcome

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

You are accepting below classification for David ATTENBOROUGH.

IAT outcome: CHSP

ACCEPT **CANCEL**

If the client receives a **Support at Home (SaH) classification**, the system displays a message explaining that the client's preference for seeking home support services determines whether they are active in the Support at Home Priority System.

Select the client's preference:

- **Seeking Services** if the client wants to access home support services through the Support at Home program.
- **Not Seeking Services** if the client does not want to access home support services at this time.

×

Accept IAT outcome

i

The client's preference for seeking Home support services determines whether they are active in the Support at Home Priority System.

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

You are accepting below classification for Name SURNAME.

IAT outcome: SaH Classification 7

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

☒ Seeking services
 ☐ Not seeking services

ACCEPT

CANCEL

If the client receives a **Support at Home (SaH) classification** and is not seeking Home support services, select **Not seeking services**. Then select a reason at the drop down:

- Deceased
- Care needs reduced
- Permanent residential care
- Other care arrangements
- Means testing
- Does not want Restorative care
- Did not wish to specify
- Returned mail
- Other. Please specify

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

☐ Seeking services ☒ Not seeking services

What is the reason for not seeking Home support services preference? *

Other. Please Specify 

Please specify *

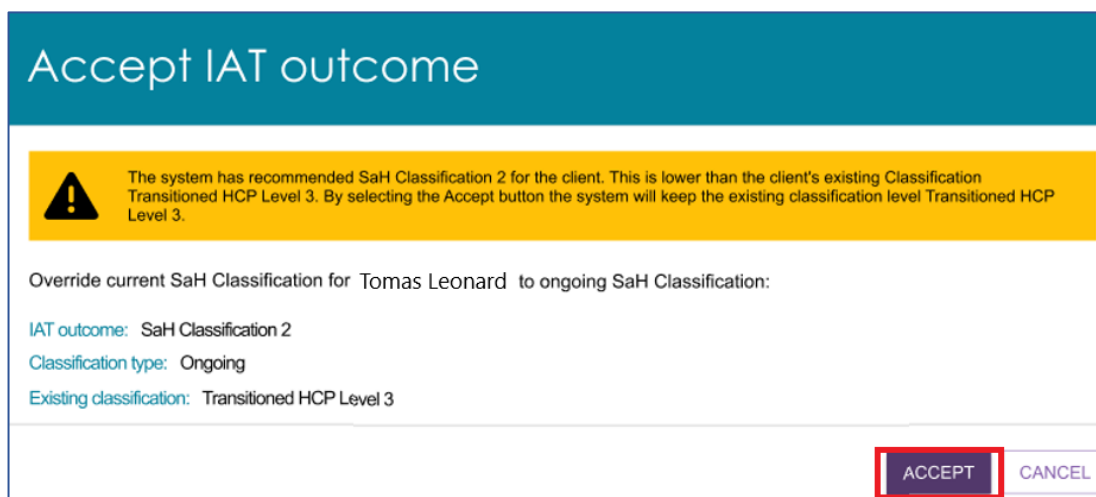
Other reason for not seeking Home support services here

The client will have any existing requests for Home support services removed, and no Home support services requested.

For further information, go to My Aged Care | www.myagedcare.gov.au | 1800 836 799 48

! Transitioned Home Care Package (HCP) clients

When you complete a reassessment for a transitioned client and the Integrated Assessment Tool (IAT) recommends a Transitioned Home Care Package (HCP) Level 1, 2, 3, or 4 classification, the system displays a warning message on the Accept IAT Outcome screen.



Accept IAT outcome

 The system has recommended SaH Classification 2 for the client. This is lower than the client's existing Classification Transitioned HCP Level 3. By selecting the Accept button the system will keep the existing classification level Transitioned HCP Level 3.

Override current SaH Classification for Tomas Leonard to ongoing SaH Classification:

IAT outcome: SaH Classification 2
 Classification type: Ongoing
 Existing classification: Transitioned HCP Level 3

ACCEPT **CANCEL**

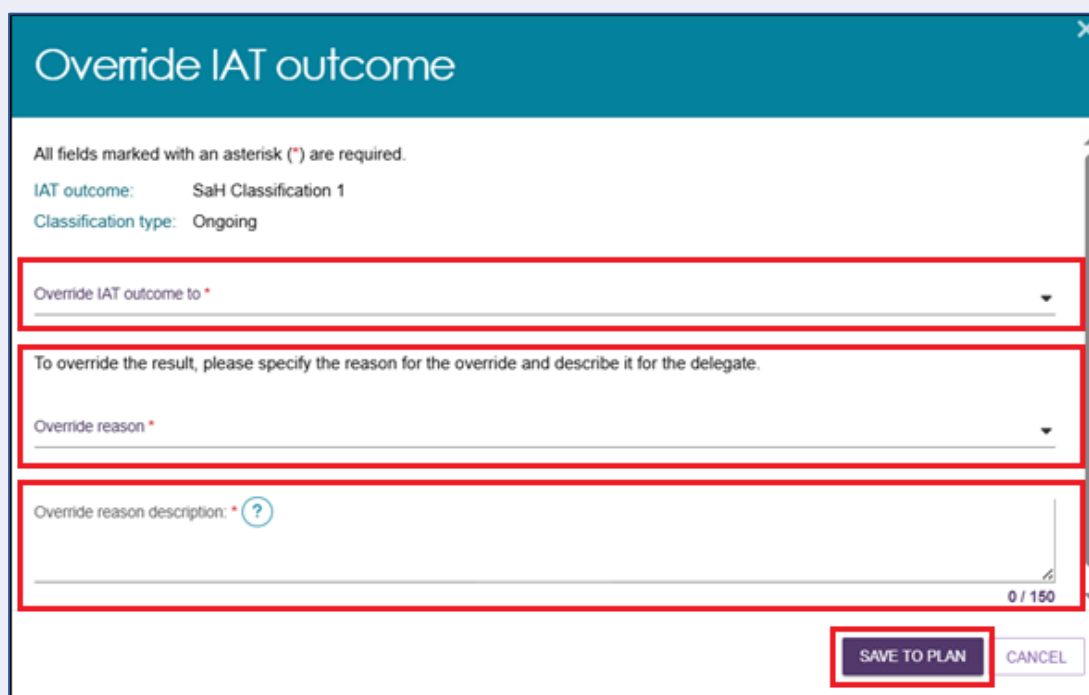
Overriding IAT Outcome

When you select **Override**, the **Override IAT Outcome** window opens.

Enter the following information:

- the outcome you want to override the IAT recommendation to
- the reason for the override
- a description explaining the override reason.

After entering the required information, select **Save to Plan**.



Override IAT outcome

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

IAT outcome: SaH Classification 1
 Classification type: Ongoing

Override IAT outcome to *

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

Override reason *

Override reason description: * ?

0 / 150

SAVE TO PLAN **CANCEL**

If the recommended classification is **Support at Home**, **End of Life**, or a **Residential Care Program**, the system takes you to the Add Home Support Services page. Review the recommended services and choose whether to accept or override them.

Refer to [My Aged Care – Assessor Portal User Guide 7 – Completing a support plan and support plan review](#) for information on how to add Home support services.

! Legislation and Overriding IAT Outcomes

In line with legislation, you are not permitted to:

- recommend a different ongoing Home Support classification level.
- override 'Ineligible for CHSP/SaH' to any ongoing Home Support services.

You are permitted to recommend short-term pathways and Residential Care according to the rules of the [My Aged Care Assessment Manual](#).

Recommending ongoing Home Support services via Support at Home or CHSP

- Ensure the recommended classification aligns with the IAT outcome.
- If after an IAT review, the IAT outcome shows a lower classification than the client's current classification, ensure the recommended classification is equivalent to the client's existing classification.



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

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

Recommending SaH Restorative Care Pathway

Assessors can override an IAT outcome (SaH Classifications 1–8, and Ineligible for CHSP/SaH) to SaH Restorative Care Pathway (RCP). This applies to both initial assessments and reassessments, and to transitioned and non-transitioned clients.

When you override the outcome to SaH Restorative Care Pathway, the system automatically adds **Assistive Technology (AT) Medium** and **Home Modifications (HM) Medium** recommendations. You can review, change, or remove these recommendations if needed.



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

Overriding the outcome to **RCP** may remove some existing recommendations. If required, add these recommendations back to the support plan.



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

1. Select 'SaH Restorative Care Pathway' at the **Override IAT Outcome** to drop-down.
2. Select an override reason at the **Override reason** drop-down

The override reasons available for this pathway are:

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

×

Override IAT outcome

i

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

!

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

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

!

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

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

IAT outcome:

SaH Classification 4

Classification type:

Ongoing

Override IAT outcome to *

SaH Restorative Care Pathway

Classification type:

Short term

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

Override reason *

Please select...

Please select...

Has restorative care goals

Delay/prevent ongoing services

Needs early intervention care

Other

SAVE TO PLAN

CANCEL

3. Enter the override reason description in the text box below the drop-down.

Override reason *

Other

Override reason description: *

Override reason description

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4. Finally, select **SAVE TO PLAN**.

! Recommending RCP From Ongoing SaH Classification only

The IAT also allows 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.

Overriding for transitioned clients undergoing reassessment

For transitioned clients being reassessed, the Override IAT Outcome list shows:

- all Support at Home (SaH) classifications that are the same as or higher than the client's current Active Transitioned Classification
- SaH Restorative Care Pathway
- SaH End-of-Life Pathway.

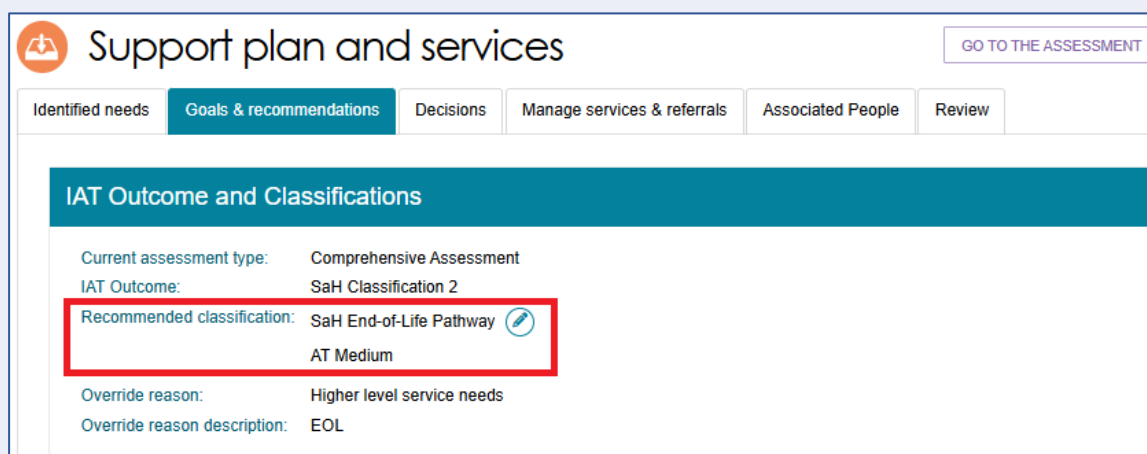
The list does not show the client's current IAT outcome.

If the IAT outcome is higher than the client's Active Transitioned Classification, the list also includes the client's current Active Transitioned Classification as an override option.

Overriding to the SaH End-of-life Pathway

When you select **SaH End-of-Life Pathway** and confirm the override, the system automatically applies the appropriate **latent classification** based on the override rules.

The system also automatically selects **Assistive Technology (AT) Medium**.



Support plan and services GO TO THE ASSESSMENT

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: SaH Classification 2

Recommended classification: SaH End-of-Life Pathway 

AT Medium

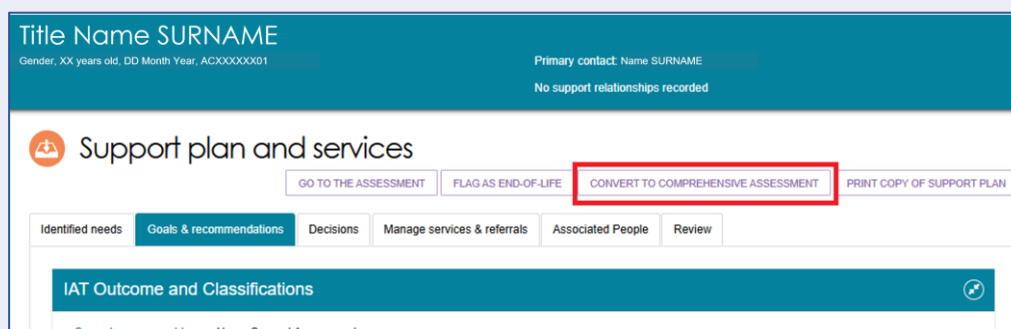
Override reason: Higher level service needs

Override reason description: EOL

Converting to Comprehensive Assessment

Non-clinical assessors can change a Home Support Assessment to a Comprehensive Assessment after finalising the IAT and receiving an outcome recommendation, provided their organisation delivers both assessment types.

1. On the **Goals & Recommendations** tab, select **Convert to Comprehensive Assessment** in the top-right corner of the page.



Title Name SURNAME
Gender, XX years old, DD Month Year, AGXXXXXX01 Primary contact: Name SURNAME
No support relationships recorded

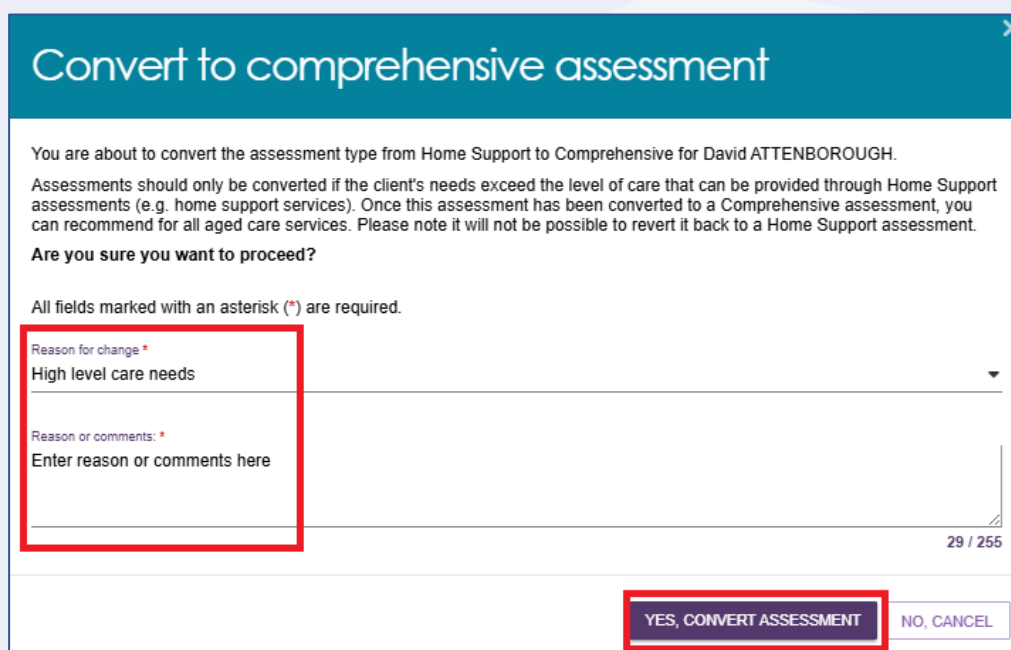
Support plan and services GO TO THE ASSESSMENT FLAG AS END-OF-LIFE **CONVERT TO COMPREHENSIVE ASSESSMENT** PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications 

Current assessment type: Home Support Assessment

2. The system automatically selects **High Level Care Needs** as the reason for the conversion. Enter any additional comments, then select **Yes, Convert Assessment**.



Convert to comprehensive assessment ×

You are about to convert the assessment type from Home Support to Comprehensive for David ATTENBOROUGH.

Assessments should only be converted if the client's needs exceed the level of care that can be provided through Home Support assessments (e.g. home support services). Once this assessment has been converted to a Comprehensive assessment, you can recommend for all aged care services. Please note it will not be possible to revert it back to a Home Support assessment.

Are you sure you want to proceed?

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

Reason for change *
High level care needs

Reason or comments: *
Enter reason or comments here

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YES, CONVERT ASSESSMENT NO, CANCEL

- The system displays a green confirmation message to confirm the assessment has been converted successfully. The **IAT outcome** also updates to show that a **Comprehensive Assessment** has been completed.

The screenshot shows the 'Support plan and services' page for a client named 'Name SURNAME'. The page includes tabs for 'Identified needs', 'Goals & recommendations', 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. A red box highlights the 'Current assessment type: Comprehensive Assessment' and the 'IAT Outcome: CHSP'. A green confirmation message at the bottom states 'Assessment type has been changed'. Navigation buttons at the top right include 'GO TO THE ASSESSMENT', 'FLAG AS END-OF-LIFE', and 'PRINT COPY OF SUPPORT PLAN'.

Flagging an Assessment as End of Life

If a qualified health professional has assessed the client and provided supporting evidence that the client is approaching end of life, you can flag the client as **End of Life**.

- In the **Current Assessments** tab, go to the **Assessment Not Started** section and select the **expand card** icon for the client.

The screenshot shows the 'Assessment Not Started' section with two client cards. Each card displays the client's name 'Name SURNAME', location 'SUBURB, STATE, POSTCODE', and dates for 'Aged care user ID: ACXXXXXX01', 'Date accepted: DD Month Year', and 'Completed Triage due by: DD Month Year'. A red box highlights the 'Assessment Not Started' header, and another red box highlights the expand card icon on the right side of the second client card.

- In the pop-up window, select **Flag as End of Life**.

The screenshot shows the client assessment details pop-up window for 'Name SURNAME'. It includes sections for 'Preferences', 'Assessment details', 'Client story', and 'Comments'. The 'Assessment details' section shows 'Assessment type: Comprehensive', 'Assessment reason: Self-Referral', 'Assessment setting: Non-Hospital', 'Assessor: Name SURNAME', and 'Triage conducted by: Name SURNAME'. The 'Client story' section shows 'Completed Triage due by: DD Month Year' and 'Client story: No client story was recorded'. At the bottom, there are buttons for 'VIEW FULL CLIENT RECORD', 'VIEW CLIENT REPORT', 'REFER URGENT SERVICES', 'START ASSESSMENT', and 'FLAG AS END OF LIFE'. A red box highlights the 'FLAG AS END OF LIFE' button.

- ! You can also start the End-of-Life process while an assessment is in progress. On the client's **Goals & Recommendations** tab, select **Flag as End of Life** and follow the prompts.

3. The **Flag referral as End-of-Life** window opens. Select the appropriate verification option from the drop-down list based on the documents provided.

4. Select the **UPLOAD ATTACHMENT** button to start uploading documents.

- ! If the client cannot provide the required documents, or the documents are not valid, you can complete the verification process from the **Goals & Recommendations** tab by selecting **Verify End of Life Form** in the top-right corner of the page.

XX Street Name, SUBURB, STATE, POSTCODE No support relationships recorded

Support plan and services

GO TO THE ASSESSMENT VERIFY END OF LIFE FORM PRINT

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

Outcome and Classifications

Assessment type: Comprehensive Assessment

5. The **Add Attachment** window opens. Upload documents from the qualified medical professional that support the client's end-of-life diagnosis.

Select **Choose File** and upload the required document. Make sure the document meets all requirements shown on the screen.

Add Attachment

i Please note: Some attachments will be viewable by other people with authorised access to this client record. Please refer to your portal guide for details.

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

Attachments

Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format. *

CHOOSE FILE Medical S...ment.docx

Attachment type *

Attachment name *

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Attachment description

UPLOAD CANCEL

6. Select the appropriate **Attachment Type** from the drop-down list and enter an **Attachment Name**.

Add Attachment

i Please note: Some attachments will be viewable by other people with authorised access to this client record. Please refer to your portal guide for details.

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

Attachments
Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format. *

CHOOSE FILE Medical S...ment.docx

Attachment type *

Please select...

End of Life Form

End of Life - other

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Attachment description

UPLOAD CANCEL

7. Select **UPLOAD**.

Add Attachment

i Please note: Some attachments will be viewable by other people with authorised access to this client record. Please refer to your portal guide for details.

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

Attachments
Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format. *

CHOOSE FILE Medical S...ment.docx

Attachment type *

End of Life Form

Attachment name *

Medical Diagnosis Report

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Attachment description

UPLOAD CANCEL

8. The system displays the uploaded document for review.

To upload additional supporting documents, select **Upload Attachment**. You can upload up to **five files**, provided each file meets the required criteria.

Flag referral as End-of-Life for Name SURNAME

All fields marked with an asterisk (*) are required.
Referrals flagged for the End-of-Life Pathway are given high priority.

End-of-Life form verification ?
Document reviewed - valid

Details

0 / 255

UPLOAD ATTACHMENT

Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format. *

Medical Diagnosis Report (End of Life Form) [docx 68.49KB]	16 May 2025	
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FLAG AS END OF LIFE **CANCEL**

9. Once all relevant documents are attached, Select **FLAG AS END OF LIFE**.

Flag referral as End-of-Life for Name SURNAME

Referrals flagged for the End-of-Life Pathway are given high priority.

End-of-Life form verification ?
Document reviewed - valid

Details

0 / 255

UPLOAD ATTACHMENT

Upload up to 5 files (10MB max total, 5MB max per attachment) in .jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, or .txt format. *

EoL verification document (End of Life Form) [docx 89.99KB]	16 May 2025	
Medical Diagnosis Report (End of Life Form) [docx 68.49KB]	16 May 2025	

FLAG AS END OF LIFE **CANCEL**

10. On the **Current Assessments** page, the client appears in the **Assessment Not Started** section with a **red hand icon containing a cross**, indicating that the client has been flagged as End of Life.

Started

745

025

February 2025

96 days overdue

Medium

Name

SURNAME

SUBURB, STATE, POSTCODE

Aged care user ID: ACXXXXXX01

Date accepted: DD Month Year

Completed Triage due by: DD Month Year

Comprehensive

12 days overdue

Assessment Not Started

! High

+

! More information on flagging a referral as End of Life can be found in [Assessor Portal – User Guide 7 – Completing a support plan and support plan review](#).

Cancelling an assessment

If you need to cancel an assessment, you can do this from within the assessment. Record the reason for the cancellation by adding a note or interaction to the client's record.

1. At the bottom of the assessment page, select **Cancel Assessment – No Further Action Required**.

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

2. Select the reason for cancelling the assessment from the **Reason for Ending the Assessment** drop-down list.

If you select **Client Deceased**, go to Step 4.

Cancel assessment - no further action required

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

Reason for ending the assessment *

Select one

Select one

- Client/family/rep unavailable
- Duplicate Client Record
- Interpreter not available
- Unable to contact client
- Outside assessment region
- Assessment no longer required
- ACAT assessment required
- RAS assessment required
- Care approval meets needs
- Client age - alternate options
- Client does not consent
- Clinical staff not available
- Client prefers an FNAO
- Hospital assessment required
- Client prefer later assessment
- Client medically unstable
- Client deceased
- Other

3. Enter comments explaining why you are ending the assessment, then select **Cancel Assessment**.

Cancel assessment - no further action required

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

Reason for ending the assessment *
Assessment no longer required

Comment: *
Comment here

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CANCEL ASSESSMENT TAKE ME BACK TO THE ASSESSMENT

4. If you cancel an assessment because the client has died, enter the following information and then select **Cancel Assessment**:
- who informed you of the client's death, when they informed you, and how they informed you (for example, *"Mrs Smith called to advise that Mr Smith passed away on Saturday"*)
 - the client's **date of death**, if known
 - any supporting attachments, such as a **death certificate** or **hospital discharge documents**

Cancel assessment - no further action required

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

Reason for ending the assessment *
Client deceased

You are about to notify the department that Maple May has passed away. Their record will become read only. You will still be able to finalise outstanding assessments and support plan reviews, and add notes and attachments.

Please supply the following information:

Who, when and how were you informed that this person is deceased? * ?

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Date of death (if known)

dd/mm/yyyy

Add Attachments

You can upload files up to 5 MB to this record. The following file types are accepted:
.jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .txt
(if available)

Choose a file...

Comment: *

0 / 200

CANCEL ASSESSMENT TAKE ME BACK TO THE ASSESSMENT

- ! If you cancel an assessment because the client is deceased, the system updates the client's status to **Deceased** and changes their record to **read-only**.

The system also:

- recalls any unaccepted service referrals
- stops any services currently in place
- removes the client's access to the client portal.

After the status changes to Deceased, My Aged Care no longer sends correspondence to the client or their supporters.

If the client is active in the Support at Home Priority System or has been assigned aged care services, the system removes them from the priority system and withdraws any assigned services.

5. The system displays a confirmation message to show that the assessment has been cancelled successfully.

The system then takes you to the **Client Summary** page, where the assessment status appears as **Cancelled**.



6. After you cancel the assessment, the client's information moves to the **Recent Assessments** tab.

You can still find the client later using the **Find a Client** search function.

A screenshot of the 'Recent assessments' page in the My Aged Care system. The page title is 'Recent assessments' with a sub-header 'Currently viewing ABC Outlet'. There are two tabs: 'Current assessments' and 'Recent assessments', with the latter highlighted by a red box. Below the tabs are 'Filter by' and 'Sort by' options. The 'Sort by' dropdown is set to 'Assessment Priority' and 'High to Low'. A 'GO' button is next to it. Below the sorting options, it says 'Current sort order is Assessment Priority' and '1 to 21 out of 21 matching results'. A red box highlights the text 'Assessment Cancelled' at the top of the first assessment card. The card shows 'Name SURNAME', 'Aged care user ID: ACXXXXXX01', 'Date accepted: DD Month Year', and a status of 'Assessment Cancelled' with a red 'High' priority indicator. Other cards show 'Assessment Cancelled' with a green 'Low' priority indicator.