

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

This user guide is for aged care needs assessors who use the My Aged Care Assessor Portal to complete a support plan or conduct a Support Plan Review.

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

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

This is available from your Assessment Organisation.

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

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

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

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

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

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The Support Plan

A client's support plan records their care needs and outlines how to address them. It includes:

- Areas where the client needs support or has concerns about their care.
- Goals the client wants to achieve.
- Recommended services or actions to help achieve those goals.

During the face-to-face assessment, the client works with the assessor to develop their support plan.

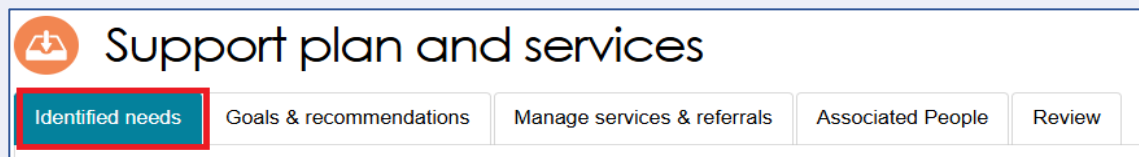
The **Support Plan** contains the following tabs:

- **Identified Needs** – records the client's care and support needs.
- **Goals & Recommendations** – records the client's goals and recommended services or actions.
- **Manage Services & Referrals** – manages service referrals and referral status.
(Refer to [My Aged Care – Assessor Portal User Guide 8 – Referring for services](#))
- **Associated People** – lists people linked to the client's support plan.
- **Review** – records when the support plan should be reviewed.

This guide focuses on the **Goals & Recommendations** tab.

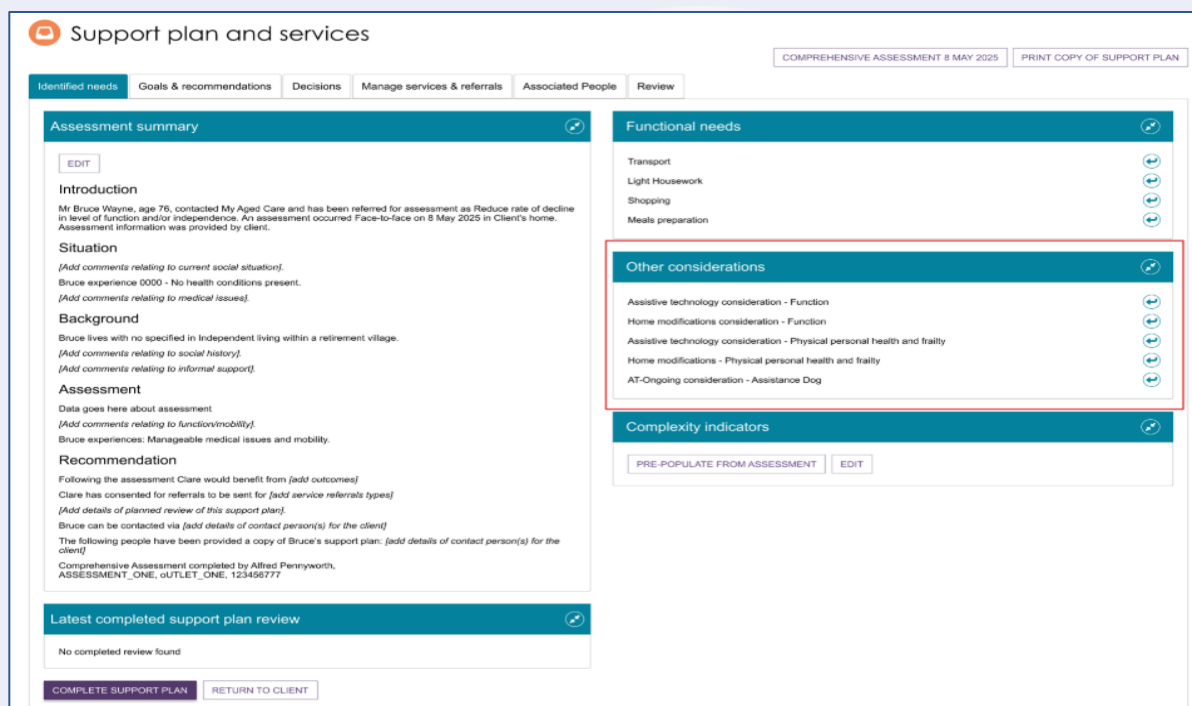
The Identified needs tab

The **Identified Needs** tab summarises the needs identified during the assessment that must be addressed in the client's support plan. If the client has completed a Support Plan Review, the tab also displays information from their most recent review.



The screenshot shows the top section of the 'Support plan and services' interface. It features a header with a red icon and the title 'Support plan and services'. Below the header is a row of five tabs: 'Identified needs', 'Goals & recommendations', 'Manage services & referrals', 'Associated People', and 'Review'. The 'Identified needs' tab is highlighted with a red border.

Headings in the Identified Needs tab

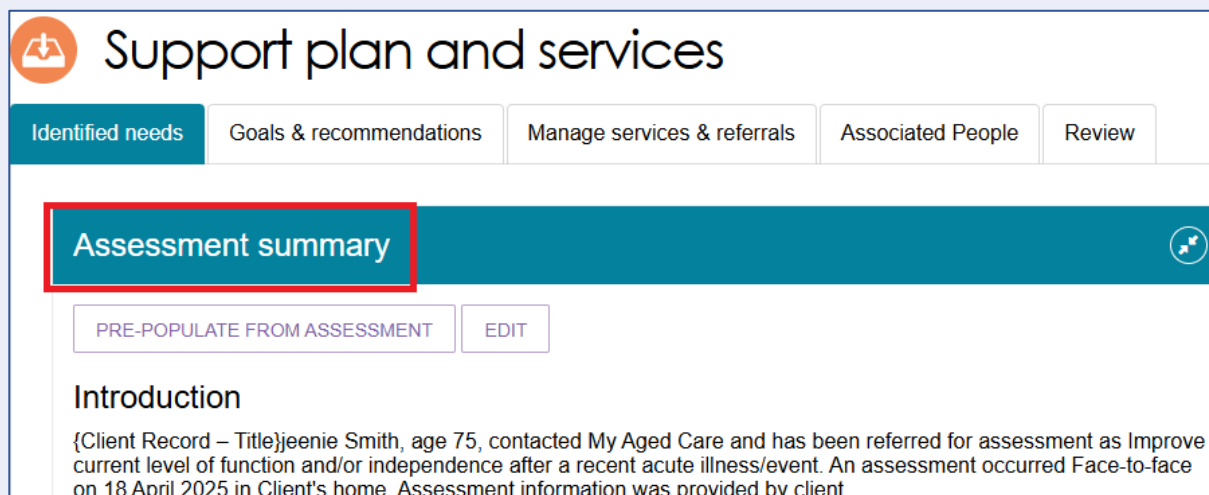


The screenshot displays the 'Identified needs' tab within the 'Support plan and services' interface. The tab is active, and the 'Assessment summary' section is expanded. The 'Assessment summary' section includes an 'EDIT' button and a detailed introduction about Mr. Bruce Wayne. Below the introduction are sections for 'Situation', 'Background', 'Assessment', and 'Recommendation'. To the right of the 'Assessment summary' is the 'Functional needs' section, which lists various needs like Transport, Light Housework, Shopping, and Meals preparation. Below 'Functional needs' is the 'Other considerations' section, which lists various considerations like Assistive technology consideration - Function, Home modifications consideration - Function, Assistive technology consideration - Physical personal health and frailty, Home modifications - Physical personal health and frailty, and AT-Ongoing consideration - Assistance Dog. Below 'Other considerations' is the 'Complexity indicators' section, which includes buttons for 'PRE-POPULATE FROM ASSESSMENT' and 'EDIT'. At the bottom of the 'Identified needs' tab is the 'Latest completed support plan review' section, which shows 'No completed review found'. At the very bottom of the interface are two buttons: 'COMPLETE SUPPORT PLAN' and 'RETURN TO CLIENT'.

Adding an assessment summary

When completing a support plan, you can add an **Assessment Summary** in the **Identified Needs** tab.

The Assessment Summary appears on the printed support plan provided to the client. It can also support future assessments and is visible to service providers who receive a referral for the client.



Support plan and services

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

Assessment summary

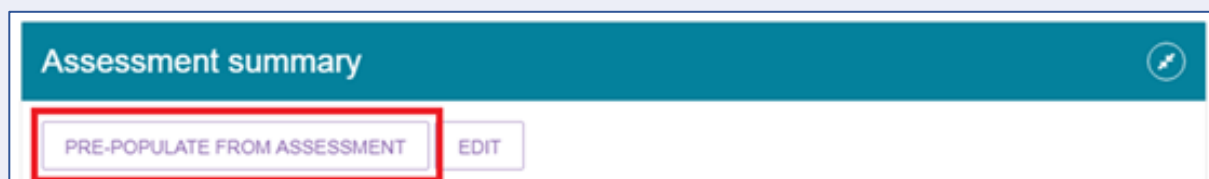
PRE-POPULATE FROM ASSESSMENT | EDIT

Introduction

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

To create an Assessment Summary using information recorded in the assessment:

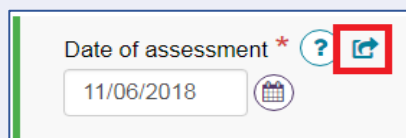
1. Select **PRE-POPULATE FROM ASSESSMENT**.



Assessment summary

PRE-POPULATE FROM ASSESSMENT | EDIT

2. The system automatically adds available information from the assessment. Information that can be automatically included is marked with an icon (an arrow leaving a square).



Date of assessment * ? [icon]

11/06/2018 [calendar icon]

3. You can:
 - enter the missing information in the assessment
 - add the information directly to the Assessment Summary
 - remove the instruction from the Assessment Summary.
4. If information is missing, the system displays the field name in square brackets, for example, **[field name]**. The system may also display prompts for information that cannot be automatically populated, for example, **[example instruction]**.

Support plan and services

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

Assessment summary

PRE-POPULATE FROM ASSESSMENT | **EDIT**

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

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

Background

If you want to create or update the Assessment Summary manually:

1. Select **EDIT**.

Assessment summary

PRE-POPULATE FROM ASSESSMENT | **EDIT**

2. Select **CONFIRM EDIT** to open the editable version.

After you select **CONFIRM EDIT** and save your changes, the **PRE-POPULATE FROM ASSESSMENT** option is no longer available.

Assessment Summary

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

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

CONFIRM EDIT | CANCEL

3. Enter or update the required information.

The Assessment Summary has a limit of **5,000 characters**. If pre-populated information causes the summary to exceed this limit, remove or summarise older content to reduce its length.

4. When you finish updating the Assessment Summary, select **SAVE**.



You can continue to edit the Assessment Summary after saving. Save your work regularly, as the Assessment Summary does not support auto-save.

Goals and recommendations tab

The **Goals & Recommendations** tab is where you record the client's areas of concern, goals, and any recommended services or other actions to help address those concerns.

This tab also displays the client's **Integrated Assessment Tool (IAT)** outcome and recommended classification(s). The system determines the recommendation(s) based on information recorded in the IAT assessment and the client's current care approvals.

In some cases, more than one active approval may appear. For example, if a client has an active Restorative Care Pathway (RCP) approval and receives a Support at Home (SaH) Classification 1-8 approval following a reassessment, the tab will display both classifications.

Identified needs	Goals & recommendations	Decisions	Manage services & referrals	Associated People	Review
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Accepting the IAT Recommendation

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

Support plan and services

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

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: SaH Classification 5

ACCEPT OVERRIDE

Overriding the IAT Recommendation

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

! The IAT allows an ongoing Support at Home classification to be overridden to a different ongoing classification level. However, assessors must not do this, and delegates must not approve assessments where it has occurred.

You cannot override an ongoing Support at Home classification outcome to a higher or lower ongoing Support at Home classification level. This requirement aligns with section 81-10 of the Aged Care Rules.

1. To override a recommended classification, select **OVERRIDE** under the **IAT Outcome and Classifications** heading.

Support plan and services

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

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: SaH Classification 5

ACCEPT **OVERRIDE**

2. The **Override IAT Outcome** pop-up appears. Enter:

- the new classification
- the override reason
- the override reason description.

The classifications available for selection depend on the original IAT outcome. You can only select classifications that comply with the Aged Care Rules. For more information, refer to the [My Aged Care Assessment Manual](#).

The appearance of the pop-up and the available options vary depending on the original IAT outcome and the override you choose. Below is an example of an Override IAT outcome pop up.

If you are overriding to any classification other than Restorative Care Pathway, select an option from the **RCP reject reason** drop-down list.

The available options are:

- **Not suitable/eligible for RCP**
- **Seeking ongoing services**
- **Other.**

(If you are overriding to **Restorative Care Pathway**, refer to the [Overriding to Restorative Care Pathway](#) section of this guide).

If you select **Other**, enter a description explaining the reason.

3. If you select a **Support at Home** classification, indicate whether the client is seeking Support at Home services by selecting:
- **Seeking services**, or
 - **Not seeking services**.

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

☒ Seeking services ☐ Not seeking services

An information message may appear to remind you that the client's preference determines whether they are included in the **Support at Home priority system**.

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

4. Select **SAVE TO PLAN**, **OVERRIDE**, or **ACCEPT** after you complete all fields.
5. After you accept or override the classification or recommendation, the system opens a new screen. Use this screen to select the services available under the classification that you want the client to receive, and record the frequency and intensity for each service.

This example of the **Add Home Support Services** page displays the services available under each service type. For example, the **Allied Health and Therapy** service type may include several services for you to choose from.

Add Home Support Services

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

Recommended that the client receive: SaH Restorative Care Pathway
Classification Type: Short-term

Please select services within each service type*

Allied health and therapy

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

6. Enter all required values, then select **SAVE TO PLAN** at the bottom of the page.

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

☐ Remedial message

Transport

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

SAVE TO PLAN CANCEL

7. The system displays the updated classification on the client's **Goals and Recommendations** tab.

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

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

IAT Outcome and Classifications

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

Client concerns and goals

No client concerns or goals.

Other recommendations

Recommend that the client receive
Home support

If the client already has an existing classification, the system displays it beside the updated classification in the **Existing Classification** section.

The image below shows an example of a client with a Transitioned HCP Classification under Support at Home, as per the *Aged Care Act 2024*. This is displayed in the Existing Classification section.

Support plan and services REQUEST ASSESSMENT PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 8

Existing classification: Transitioned HCP Level 4

The system displays this existing classification for reference only. You must still select the services the client requires.

For **clinical aged care needs assessors** (clinical assessors):

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

For **non-clinical aged care needs assessors** (non-clinical assessors):

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

Types of Recommendations

You can add or remove seven types of recommendations in a support plan after completing an assessment:

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

General recommendations are non-Commonwealth funded supports that you and the client identify. The client or assessor actions these recommendations, not a service provider. For example, you may recommend that the client visit a health professional or join a local support group.

Service recommendations add funded services to the client's support plan, such as Commonwealth Home Support Programme (CHSP) services.

Assistive technology recommendations provide access to assistive technology through the Support at Home program.

Home modification recommendations provide access to home modifications through the Support at Home program.

Recommended long-term living arrangement applies only to comprehensive assessments. After discussing goals with the client and/or their supporter, select the most suitable long-term living arrangement from the available accommodation options. You can only add this recommendation after completing a comprehensive assessment.

Care type for Delegate decision recommendations apply only to comprehensive assessments where CHSP is not recommended. These recommendations relate to care types under the *Aged Care Act 2024* and require Delegate approval.

Linking support recommendations apply when a client's complex circumstances make it difficult to access aged care services. Linking support helps the client connect with the services they need.

Recommendations for a period of reablement provide time-limited interventions that help the client achieve specific goals or outcomes. These interventions can help the client adapt to a loss of function, regain confidence, or improve their ability to carry out daily activities. Examples include learning a new skill, modifying the home environment, or accessing equipment or assistive technology.

Linking Recommendations to Goals

Recommendations can be linked to one or more concerns and goals, or you can add them as **Other Recommendations**. For more information about **linking support** and **reablement**, refer to the [My Aged Care Assessment Manual](#).

A recommendation can be linked to multiple goals. When you add a recommendation, you can link it to one or more goals, or leave it unlinked.

1. In the **Other Recommendations** section of the **Goals & Recommendations** tab, select the recommendation you want to add. You can then choose whether to link the recommendation to a relevant goal. The recommendation will appear under the **Other Recommendations** heading.

DEPARTMENT OF TOLLESTE AVENUE CASTLE HILL, NSW, 2124

No support relationships recorded

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

ADD A GOAL

Goal: To be able to perform household tasks

Other recommendations

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

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

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

Recommend that the client receive
Transport 9 May 2025

Recommend that the client receive
Home Support

Recommend that the client receive
Home Modifications

You can also add a recommendation directly to an area of concern and goal. Select the double arrow next to the goal, then select an option under **Add to this goal** on the right side of the panel.

When you add a recommendation this way, the recommendation appears under the selected goal.

To view the recommendation details, select the double arrow to the left of the goal.

Goal: To be able to perform household tasks

Most relevant domain that goal area relates to:

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

Client's current strengths and abilities in relation to this goal:
Can sit and stand up without help for sometime

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

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

Motivation to achieve: 8

Status: In Progress

Recommendations

Recommend that the client receive
Client Care Coordination 9 May 2025

Recommend that the client receive
Domestic assistance

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

Recommendation
Exercise twice per week
Responsibility to action: Client
Recommended by: Sam Myers

Add to this goal:

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

LINK TO THE EXISTING PLAN RECOMMENDATIONS

- To remove the link between a recommendation and its associated goals, select the **Edit** (pencil) icon next to the recommendation. Select **UNLINK THIS RECOMMENDATION FROM ALL GOALS**, then select **SAVE TO PLAN**.

Edit service recommendation

Priority and dates

Priority *
Medium

Recommended service frequency ? Recommended service intensity ?

Recommend a start date
☐ Yes ☒ No

Recommend a review date
☐ Yes ☒ No

Recommend an end date
☐ Yes ☒ No

Responsibility to action
☒ Assessor ☐ Client ☐ Other

Comments:
0 / 100

Associated goals
☒ To be able to perform household tasks

UNLINK THIS RECOMMENDATION FROM ALL GOALS

SAVE TO PLAN CANCEL

Viewing the Recommendation after a delegate decision

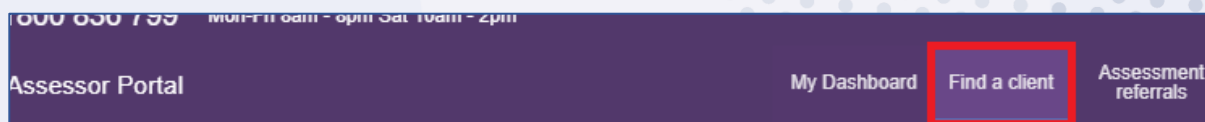
After you enter the goals and recommendations, send the assessment to the delegate for review and decision-making.

Once the delegate completes their review, you can view the outcome and find out:

- which recommended services the delegate approved
- which recommended services the delegate modified
- any new services the delegate added.

To view this information:

- Use **Find a Client** in the Assessor Portal to open the client record.



2. Select the **Plans** tab, then select **Support Plan**.

Plans

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

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

SUPPORT PLAN

Recommendations

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

[SEE SERVICE DETAILS](#)

Upcoming Review(s)
No upcoming reviews scheduled

Assessment history

- Comprehensive
- Screening 29 August

Plan history

- [Support plan as at 3 September 2024](#)
- [Support plan as at 3 September 2024](#)

Review history
No review history available

Reablement assessment
No linking support items

3. In the client's **Support Plan and Services** screen, select the **Decisions** tab.

The **Decisions** tab shows the outcome of the delegate's review, including any approved, modified, or newly recommended services.

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

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

IAT Outcome and Classifications

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

Current care approvals

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

4. Scroll to the **Delegate Decisions and Comments** section to view all decisions the delegate made about the services recommended for the client.

This section provides a detailed summary of:

- approved services
- modified services
- newly recommended services
- any comments or reasons provided by the delegate.

Delegate decisions and comments

Assessment: Submitted on 29 January 2026

Decisions



Recommend that the client receive

Home support

Classification: SaH Classification 7

Classification type: Ongoing

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

Approval start: 29 January 2026

● Agreed



Recommend that the client receive

Assistive technology

Assistive technology tier: AT Medium

Classification type: Short-term

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

Approval start: 29 January 2026

Cease date: 23 April 2027

● Agreed



Recommend that the client receive

Home modifications

Home modifications tier: HM High

Classification type: Short-term

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

Approval start: 29 January 2026

Cease date: 23 April 2027

● Agreed

Decision date (Assessment)

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

Adding Recommendations

- To add a general recommendation, go to [General Recommendation](#).
- To add a service recommendation, go to [Service Recommendation](#).
- To add a Home modification, go to [Adding a Home modification Recommendation](#).
- To add an Assistive technology Service, go to [Adding Assistive technology Recommendation](#).
- To add a recommendation for a period of linking support, go to [Period of Linking Support](#).
- To add a recommendation for a period of reablement, go to [Period of Reablement](#).
- To add a recommendation for a Care type for Delegate decision, go to [Care type for Delegate decision](#).
- To add a recommendation of No Care Type Under the Act, go to [No Care Type Under the Act](#).
- To add a recommendation for No Care Approval or for No Change to Existing Care Approvals, go to [No Care Approval/No Change to Existing Care Approvals](#).

General Recommendation

1. Select **Add a general recommendation**.

Examples of general recommendations include:

- Develop an emergency care plan.
 - Connect with a GP or other health professional.
 - Seek support with decision-making.
 - Obtain a smoke alarm.
 - Develop a personal emergency plan.
 - Explore getting a personal alarm.
2. When the **Add General Recommendation** pop-up appears, enter the recommendation details. If you want to link the recommendation to a goal, select the checkbox. Then select **SAVE TO PLAN**.

Add general recommendation

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

Recommendation: *

0 / 255

Responsibility to action

☐ Assessor ☐ Client ☐ Other

Comments:

0 / 100

Associated goals

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

UNLINK THIS RECOMMENDATION FROM ALL GOALS

SAVE TO PLAN CANCEL

- During the assessment, you can add general recommendations directly to the support plan. Select **Add as Recommendation** to include the recommendation in the client's support plan. The recommendation will then appear in both the **Identified Needs** tab and the **Goals & Recommendations** tab of the support plan.

Service Recommendation

- Select **Add Service Recommendation**.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

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.

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 7
 Recommended classification: SaH Classification 7 Agreed

[CHANGE](#)

Recommended care requiring delegate decision

Recommend that the client receive
 Home support

ADD A SERVICE RECOMMENDATION [ADD A CARE TYPE FOR DELEGATE DECISION](#) [ADD NO CARE APPROVAL](#) [RECOMMEND AN ASSISTIVE TECHNOLOGY](#)

[RECOMMEND HOME MODIFICATIONS](#)

[RETURN TO ASSESSOR](#) [RETURN TO CLIENT](#)

- When the pop-up appears, select the recommended service and complete all mandatory fields.

Use the **Comments** field to describe the specific services the client needs within the recommended Support at Home service type. Base your comments on the needs identified during the assessment and the goals recorded in the support plan. For example:

- Unable to travel beyond walking distance.
- Requires transport to attend health clinic appointments.

When finished, select **SAVE TO PLAN**.

Add service recommendation

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

Service Type: *

Priority and dates

Priority *
Low

Recommended service frequency ? Recommended service intensity ?

Recommend a start date
☐ Yes ☒ No

Recommend a review date
☐ Yes ☒ No

Recommend an end date
☐ Yes ☒ No

Responsibility to action
☐ Assessor ☐ Client ☐ Other

Comments:
0 / 100

SAVE TO PLAN CANCEL

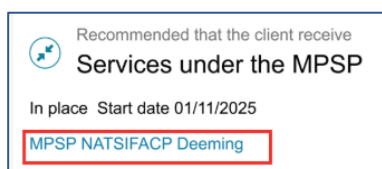
3. For Support at Home service recommendations, the system automatically applies the priority calculated by the **Integrated Assessment Tool (IAT)**.

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

! Transitioned Clients from MPS or NATSIFAC Program

Assessors can select **Services under the MPSP** and **Services under the NATSIFAC** as Service Recommendations.

The system identifies transitioned clients by the text **MPSP NATSIFAC Deeming** on the **Client Summary** page and the **Goals and Recommendations** tab of the client record.



The system also displays an information message to remind assessors that the client is approved to access services through an **MPSP** or **NATSIFAC** provider.



No Care Type Under the Act

Use **No Care Type Under the Act** when a client withdraws their application for care under the *Aged Care Act*. This outcome does not require delegate approval.

This option is available before you accept or override the IAT outcome. It does not appear if you accept an IAT recommendation for a **Support at Home (SaH)** or **CHSP** classification.

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

In some cases, **Add No Care Type Under the Act** may be the only available recommendation. When this occurs, all other recommendation options are unavailable until you accept or override the IAT outcome.

Support plan and services

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

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

IAT Outcome and Classifications

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

ACCEPT OVERRIDE

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

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

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

RECOMMEND A PERIOD OF REABLEMENT ADD NO CARE APPROVAL

There are no service recommendations for this client

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

2. When the pop-up appears, select the reason for recommending **No Care Type Under the Act**. Add comments if required, then select **SAVE TO PLAN**.

No care type under the Act

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

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

Reason: *
Client withdrew application

Reason or comments (optional)
Maximum 255 characters

0 / 255

SAVE TO PLAN CANCEL

3. If you add **No Care Type Under the Act** from the **Other Recommendations** section, the recommendation appears under that heading. The system does not link this recommendation to a goal.

No Care Approval/No Change to Existing Care Approvals

No Care Approval and **No Change to Existing Care Approvals** are special care type recommendations that [require a delegate decision](#).

Comprehensive assessors and home support assessors can add either recommendation to an IAT assessment and submit the assessment to a delegate for approval before they finalise the support plan.

You cannot use these options during a support period or a support plan review.

Use **No Care Approval** when:

- the client has no previous care approvals
- the client has been assessed
- no services or care approvals are recommended because the IAT outcome shows the client is not eligible for CHSP or Support at Home based on their assessed needs.

You must accept the IAT outcome before selecting this option.

Use **No Change to Existing Care Approvals** when:

- you are completing a reassessment, and
- the reassessment does not change the client's existing care approvals.

This option requires delegate approval and is only available when the client already has care approval records.

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

1. Select **NO CARE APPROVAL** or **NO CHANGE TO EXISTING CARE APPROVALS** from the **Other Recommendations** section. You can also add these recommendations directly to a client's goal.

No Care Approval example

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: Home Support Assessment

IAT Outcome: Ineligible for CHSP/SaH

Recommended classification: Ineligible for CHSP/SaH

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION RECOMMEND A PERIOD OF LINKING SUPPORT RECOMMEND A PERIOD OF REABLEMENT ADD NO CARE APPROVAL

There are no service recommendations for this client

No Change to Existing Care Approvals example

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: CHSP

Recommended classification: CHSP

Existing classification: CHSP

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

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

RECOMMEND A PERIOD OF REABLEMENT ADD NO CHANGE TO EXISTING CARE APPROVALS

Adding recommendation directly to a goal

Client concerns and goals

ADD AREA OF CONCERN

Concern:
Mobility within the home

ADD A GOAL

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

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

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

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

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

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

Motivation to achieve: 1

Status: In Progress

Recommendations

Add to this goal:

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

LINK TO AN EXISTING RECOMMENDATION ADD NO CARE APPROVAL

- If required, enter comments or a reason in the pop-up window.

Select **SAVE TO PLAN**.

No Care Approval example

Add no care approval

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

Reason or comments

0 / 255

SAVE TO PLAN CANCEL

No Change to Existing Care Approvals example

Add no change to existing care approvals

Reason or comments

0 / 255

SAVE TO PLAN CANCEL

- The recommendation appears in the client's **Goals & Recommendations** section of the support plan. A confirmation message displays to show that the recommendation has been added. Submit the assessment to a delegate for decision and approval.

No Care Approval example

Recommend that the client receive

No Care Approval

(not yet in place)

This recommendation requires a delegate decision

Priority for this care type: Low

Recommended by: Oni Traversi (Assessor) Grand Willow Health

23 July 2026

COMPLETE SUPPORT PLAN RETURN TO CLIENT

✓ Your recommendation has been added

No Change to Existing Care Approvals example

Recommend that the client receive

No Change to Existing Care Approvals

(not yet in place)

This recommendation requires a delegate decision

Priority for this care type: Low

Recommended by: Obi Traversi (Assessor) Grand Willow Health

23 July 2026

COMPLETE SUPPORT PLAN RETURN TO CLIENT

✓ Your recommendation has been added

! CHSP, MPSP or NATSIFAC in the support plan

If the client already has a **CHSP**, **MPSP**, or **NATSIFACP** recommendation in their support plan, including CHSP services marked as **urgent**, you can complete the support plan for a comprehensive assessment without adding:

- **Care Type for Delegate Decision**
- **No Care Approval**
- **No Change to Existing Care Approvals.**

Otherwise, an error message will appear:



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

Period of Linking Support

1. Select **RECOMMEND A PERIOD OF LINKING SUPPORT**.
2. When the pop-up appears:
 - Enter the start date and recommended end date for the linking support period.
 - Select a reason for recommending linking support from the drop-down list.
 - Add any relevant comments.
 - Link the recommendation to one or more goals if applicable.
 - Select **RECOMMEND** to save the recommendation to the client's support plan.

During a linking support period, you can request and receive approval for extensions to Transition Care and Residential Respite Care services.

For more information about linking support, refer to [My Aged Care Assessment Manual](#).

Recommend a period of linking support

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

What is linking support ?

Start date *
25/05/2018

Recommended end date *
(e.g. dd/mm/yyyy)

Reason for linking support period *
Short term assistance to access aged care services

Comments

Associated goals
☒ To be mobile enough to enjoy gardening and outdoor activities again.
☐ To get eyes checked and new prescription glasses.

UNLINK THIS RECOMMENDATION FROM ALL GOALS

RECOMMEND CANCEL

Period of Reablement

1. Select **RECOMMEND A PERIOD OF REABLEMENT**.
2. When the pop-up appears:
 - Enter the start date and recommended end date for the reablement period.
 - Select a reason for recommending reablement from the drop-down list.
 - Add any relevant comments.
 - Link the recommendation to one or more goals, if applicable.
 - Select **RECOMMEND** to save the recommendation to the client's support plan.

During a reablement period, you can request and receive approval for extensions to Transition Care and Residential Respite Care services.

For more information about reablement, refer to the [My Aged Care Assessment Manual](#).

Care type for Delegate decision

1. Select **ADD A CARE TYPE FOR DELEGATE DECISION**. You can add this recommendation under a goal or as a separate recommendation.

ADDING A CARE TYPE AS PART OF A GOAL

ADDING A CARE TYPE SEPARATELY

Client concerns and goals

ADD AREA OF CONCERN

Concern: Unable to perform certain household duties

ADD A GOAL

Goal: To be able to perform their household tasks

Other recommendations

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

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

2. In the pop-up window:
 - Select the appropriate care type.
 - Enter a reason and any comments, if required.
 - Select **SAVE TO PLAN**.

The available care types are:

- **Residential Permanent Care**
- **Residential Respite Care**
- **Transition Care.**

Add care type for delegate decision

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

Which care type applies? *

Select one

Select one

- No Care Approval
- Residential Permanent
- Residential Respite Care
- Transition Care

0 / 255

SAVE TO PLAN CANCEL

! If the client is under 65 years of age, complete the additional fields that record their exceptional circumstances.

3. After you select a care type, the pop-up expands to display additional fields. Enter the required information, including the priority or urgency of the care type.

For **Residential Permanent Care**, select the appropriate urgency level.

For **Residential Respite Care**, the urgency automatically defaults to **High** and cannot be changed.

Refer to the **My Aged Care Assessment Manual** for guidance on selecting the appropriate urgency level.

Add care type for delegate decision

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

Which care type applies? *

Residential Permanent

☐ Shared room + ensuite
 ☐ Shared room + no bathroom or ensuite
 ☐ Shared room + shared bathroom

☐ Single room + ensuite
 ☐ Single room + no bathroom or ensuite
 ☐ Single room + shared bathroom

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

(e.g. dd/mm/yyyy)

What is the urgency of this care type? *

Is this emergency care?

☐ Yes ☒ No

Reason or comments

SAVE TO PLAN CANCEL

For **Residential Respite Care**, make sure you:

- select the **DEMMI** checkbox, and
- enter a valid reason.

Add care type for delegate decision

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

Which care type applies? *

Residential Respite Care

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

(e.g. dd/mm/yyyy)

What is the urgency of this care type? *

High

Is this emergency care?

☐ Yes ☒ No

Reason or comments

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

Reason DEMMI not completed *

Client has not received a modified DEMMI previously

51 / 500

SAVE TO PLAN CANCEL

4. Select **SAVE TO PLAN**.

- ! If the client's home address is not recorded, the system displays a warning message prompting you to update the address before continuing.

Add care type for delegate decision

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

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

Which care type applies? *

Residential Respite Care

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

(e.g. dd/mm/yyyy)

What is the urgency of this care type? * ?

High

Is this emergency care?

☐ Yes ☒ No

SAVE TO PLAN CANCEL

Support at Home Recommendations

Adding Home Support services

After the clinical assessor accepts the Support at Home classification, add the Home Support services the client needs.

- ! If you do not select a service, the Support at Home service provider cannot deliver that service to the client. This may result in the need for a Support Plan Review to add the service to the client's Support at Home classification.

When completing a Support at Home assessment, select all relevant service types when making recommendations in the support plan. This helps reduce the number of Support Plan Reviews required.

The only exception is **Allied Health and Therapeutic Services for Independent Living**. You must select this manually based on the client's identified goals.

1. For each recommended service, select the checkbox and enter the required frequency and intensity.

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

Master Bart SAMPSON
Male, 81 years old, 1 March 1944, ACB1234567

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

REFER THIS CLIENT FOR ASSESSMENT | VIEW CLIENT REPORT

Add Home Support services

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

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

Please select services within each service type*

Home or community general respite

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

Nutrition

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

Therapeutic services for independent living

Service	Frequency	Intensity	Goals
☐ Art therapy			

- Review all recommended services and make sure you have selected the services the client needs and deselected any that are not required.
- Select **SAVE TO PLAN**.

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

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

Master Bart SAMPSON
Male, 81 years old, 1 March 1944, ACB1234567

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

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

SAVE TO PLAN | CANCEL

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Australian Government
Department of Health and Aged Care
myagedcare.gov.au

- After you save the plan, the system returns you to the **Goals & Recommendations** tab. A banner will advise that it may take up to 60 seconds for the new services to appear.

Support plan and services

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

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

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

To view the Support at Home service recommendations:

- Expand the relevant section.
- Select the **View** (magnifying glass) icon next to a service recommendation.
- Review the service details, including the recommended frequency.

Recommend that the client receive 6 May 2025

Home Support

(not yet in place)

This recommendation requires a delegate decision

Classification: SaH Classification 5

Classification type: Ongoing

Home Support services:

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

Recommended by: Brenna Hale (Assessor) Sunrise Assessments - ACA - VIC 3

COMPLETE SUPPORT PLAN **RETURN TO CLIENT**

- Use the expand buttons to view additional information.
- Select **CLOSE** to return to the support plan.

Home support services

Classification: SaH Classification 5 Classification Type: Ongoing

- Allied health and therapy**
 - Diet or nutrition: recommended frequency is 3 days per month.
- Care management
 - Home support care management:
- Domestic assistance
- Home maintenance and repairs
- Home or community general respite
 - Community and centre-based respite: recommended frequency is 2 days per month.
 - Flexible respite: recommended frequency is 3 days per week.
- Meals
- Nursing care
- Nutrition

CLOSE

- When you have finished making all required changes, select **COMPLETE SUPPORT PLAN REVIEW**.

Viewing Recommended SaH services

1. To view the details and status of services recommended under a client's Support at Home classification, go to the **Goals & Recommendations** tab and locate the **Other Recommendations** section.
2. Select the **expand** icon next to the service recommendation, then select the **View** (blue magnifying glass) icon.

Other recommendations

Recommend that the client receive
Equipment and products 8 May 2025

Recommend that the client receive
Home Support 8 May 2025

(not yet in place)

● This recommendation requires a delegate decision

Classification: SaH Classification 4
Classification type: Ongoing

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

3. A pop-up window will open and display all recommended services.

Home support services

Classification: SaH Classification 4 Classification Type: Ongoing

- ⌕ Allied health and therapy
- ⌕ Care management
- ⌕ Domestic assistance
- ⌕ Home maintenance and repairs
- ⌕ Home or community general respite
- ⌕ Meals
- ⌕ Nursing care
- ⌕ Nutrition
- ⌕ Personal care
- ⌕ Social support and community engagement
- ⌕ Transport

CLOSE

4. Select the **expand card** icon to view detailed information and the status of each recommended service.

Home support services

Classification: SaH Classification 4

Classification Type: Ongoing

Allied health and therapy

Care management

Domestic assistance

- General house cleaning: Agreed
- Laundry services: Agreed
- Shopping assistance: Agreed

Home maintenance and repairs

Home or community general respite

Meals

- Meal delivery: Linked to goal: Ability to cook Agreed

CLOSE

Assistive technology and Home modifications (AT-HM) Recommendations

This section explains how to view, add, and edit Assistive Technology and Home Modifications (AT-HM) recommendations.

Adding a Home modification Recommendation

- !** Before adding or editing a Home Modification recommendation, refer to:
- The **Support Plan** section of [My Aged Care – Integrated Assessment Tool \(IAT\) User Guide](#)
 - The **Approving AT and HM under Support at Home** and **Approving AT and HM under CHSP sections** under Chapter 8 of the [My Aged Care Assessment Manual](#)
 - The **AT-HM Scheme Guidelines** for support plans and support plan reviews. Assessment Operations Managers can access the AT-HM Tier Guide on the Assessor SharePoint site and provide it to assessors as required.
 - Assessor workforce training.

If the client has received a Support at Home classification through the IAT, you can add a Home Modification recommendation during the assessment.

- Go to the client's **Goals & Recommendations** tab in the **Support Plan and Services** screen.

If you selected **AT/HM Short-term** in the **Other Considerations** section of the IAT, the system displays a reminder message: *"Please consider the identified needs captured in the Other Considerations section when making an AT or HM funding tier recommendation."*

Support plan and services

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

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

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

IAT Outcome and Classifications

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

2. Scroll to the **Other Recommendations** section and select **ADD A HOME MODIFICATION**.

Support plan and services

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

IAT Outcome and Classifications

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

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION | ADD AN ASSISTIVE TECHNOLOGY | **ADD A HOME MODIFICATION** | ADD RECOMMENDATION

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

3. The **Add Home Modification Recommendation** screen opens.

- Select the appropriate **Home Modification Tier** from the drop-down list (**HM Low**, **HM Medium**, or **HM High**).
- The system automatically populates the associated Service Type(s).
- If required, select **Edit** next to **Linked Goals** to link relevant goals.
- For the question *"The client's preference for seeking Home Modification services through the Support at Home program is"*, select **Seeking services**.
- Select **SAVE TO PLAN**.

Add Home modifications recommendation

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

Home modifications tier *
HM Medium

Service Type *
Home adjustments

☒ Home modification products Linked goals

☒ Home modifications prescription and clinical support Linked goals

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

☒ Seeking services ☐ Not seeking services

SAVE TO PLAN **CANCEL**

4. The Home Modification recommendation will appear in the **Other Recommendations** section of the client's **Goals & Recommendations** tab.

Support plan and services

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

IAT Outcome and Classifications

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

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION **ADD A SERVICE RECOMMENDATION** **ADD AN ASSISTIVE TECHNOLOGY** **ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT** **ADD A CARE TYPE FOR DELEGATE DECISION** **ADD 'NO C**

RECOMMEND A PERIOD OF REABLEMENT

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

Recommend that the client receive **Home Modifications**

Recommend that the client receive **Assistive Technology**

Your recommendation has been added.

Viewing Home modification Service Recommendation

1. In the **Other Recommendations** section, select the **Edit** (pencil) icon next to the Home Modification recommendation.

Support plan and services

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

IAT Outcome and Classifications

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

Client concerns and goals

[ADD AREA OF CONCERN](#)

No client concerns or goals.

Other recommendations

[ADD A GENERAL RECOMMENDATION](#) [ADD A SERVICE RECOMMENDATION](#) [ADD AN ASSISTIVE TECHNOLOGY](#) [ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT](#) [ADD A CARE TYPE FOR DELEGATE](#)

[RECOMMEND A PERIOD OF REABLEMENT](#)

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

2. The system displays the details of the recommended Home Modification service.

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

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

Editing Home modification Recommendation

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

Other recommendations

[ADD A GENERAL RECOMMENDATION](#) [ADD A SERVICE RECOMMENDATION](#) [ADD AN ASSISTIVE TECHNOLOGY](#) [ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT](#) [ADD A CARE TYPE FOR DELEGATE DECISION](#)

[ADD 'NO CARE TYPE UNDER THE ACT'](#) [RECOMMEND A PERIOD OF LINKING SUPPORT](#) [RECOMMEND A PERIOD OF REABLEMENT](#)

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

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

Editing Home modifications recommendation

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

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

Home modifications tier *
HM Medium

Service Type *
Home adjustments

☒ Home modification products Linked goals 

☒ Home modifications prescription and clinical support Linked goals 

SAVE TO PLAN CANCEL

Adding an Assistive technology Recommendation

- !** Before adding or editing an Assistive Technology recommendation, refer to:
- The **Support Plan** section of [My Aged Care – Integrated Assessment Tool \(IAT\) User Guide](#)
 - The **Approving AT and HM under Support at Home** and **Approving AT and HM under CHSP** sections under Chapter 8 of the [My Aged Care Assessment Manual](#)
 - The **AT-HM Scheme Guidelines** on support plan or support plan reviews for AT-HM. Assessment Operations Managers can access the AT-HM Tier Guide on the Assessor SharePoint site and provide it to assessors as required.
 - Assessor workforce training.

If the client has received a Support at Home classification through the IAT, you can add an Assistive Technology recommendation during the assessment.

- Go to the client's **Goals & Recommendations** tab in the **Support Plan and Services** screen.

If you selected **AT/HM Short-term** in the **Other Considerations** section of the IAT, the system displays a reminder message: *"Please consider the identified needs captured in the Other Considerations section when making an AT or HM funding tier recommendation."*

 Support plan and services

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

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

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

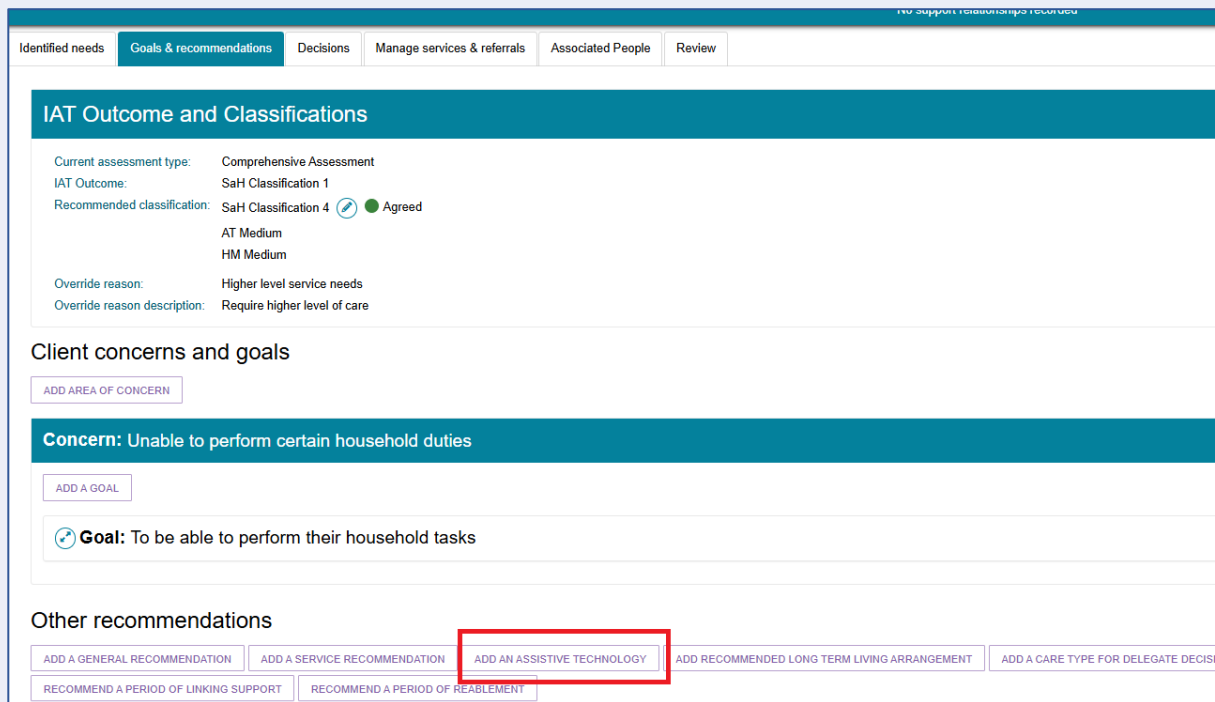
IAT Outcome and Classifications

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

The system may also display other information messages to help you make an Assistive Technology recommendation.

 The client may be suitable for Assistive technology - Ongoing delivered through Support at Home. This can be added as a recommendation through the below buttons

2. Scroll to the **Other Recommendations** section and select **ADD ASSISTIVE TECHNOLOGY**.



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

IAT Outcome and Classifications

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

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

Client concerns and goals

ADD AREA OF CONCERN

Concern: Unable to perform certain household duties

ADD A GOAL

Goal: To be able to perform their household tasks

Other recommendations

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

RECOMMEND A PERIOD OF LINKING SUPPORT **RECOMMEND A PERIOD OF REABLEMENT**

3. The **Add Assistive Technology Recommendation** screen opens.
 - Select the appropriate **Classification Type (Ongoing or Short-term)**.
 - Select either a **Specified Need** (for example, **Assistance Dogs**) or an **Assistive Technology Tier (AT Low, AT Medium, or AT High)** from the drop-down lists.
 - Based on your selection and the client's classification, the system may automatically populate and pre-select the relevant service types.
 - For the question *"The client's preference for seeking Assistive Technology services through the Support at Home program is"*, select **Seeking services**.
 - Select **SAVE TO PLAN**.
4. The Assistive Technology recommendation appears in the **Other Recommendations** section of the client's **Goals & Recommendations** tab.

 The system does not display linked goals for service recommendations carried over from a previous assessment.

Add AT recommendation - Ongoing Assistance Dogs

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

Add Assistive technology recommendation

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

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

Classification type *
Ongoing

Specified needs *
Specified needs - Assistance Dogs

Service Type *
Equipment and products

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

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

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

☒ Seeking services ☐ Not seeking services

SAVE TO PLAN CANCEL

Add AT recommendation - Short Term, Medium Tier

Add Assistive technology recommendation

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

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

Classification type *
Short-term

Assistive technology tier *
AT Medium

Service Type *
Equipment and products

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

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

☒ Seeking services ☐ Not seeking services

SAVE TO PLAN CANCEL

Viewing Assistive technology Service recommendation

- After you [add an Assistive Technology recommendation](#), it appears in the **Other Recommendations** section of the client's **Goals & Recommendations** tab.

Support plan and services

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

IAT Outcome and Classifications

Client concerns and goals

ADD AREA OF CONCERN

Concern: Unable to perform certain household duties

ADD A GOAL

 **Goal:** To be able to perform their household tasks

Other recommendations

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

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

 Recommend that the client receive
Home Support

 Recommend that the client receive
Assistive Technology

- To view the recommended Assistive Technology services, select the **Expand** icon next to **Assistive Technology**.

Other recommendations

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

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

 Recommend that the client receive
Home Support 7 May 2025 

 Recommend that the client receive
Assistive Technology 22 April 2025  

(not yet in place)

 **This recommendation requires a delegate decision**

Assistive Technology Tier: AT Medium

Classification type: Short-term

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

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

Editing Assistive technology Recommendation

1. In the **Other Recommendations** section, select the **Edit** (pencil) icon in the upper-right corner of the Assistive Technology recommendation.

2. The **Edit Assistive Technology Recommendation** screen opens.
Make the required changes and select **SAVE TO PLAN**.

Adding Client Concerns and Goals

- On the Support Plan and Services page, select the **Goals & Recommendations** tab.
In the **Client Concerns and Goals** section, select **ADD AREA OF CONCERN**.

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

Support plan and services

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

IAT Outcome and Classifications

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

Client concerns and goals

ADD AREA OF CONCERN

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

Add area of concern

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

What is the area of concern? *

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

109 / 500

SAVE TO PLAN CANCEL

- The area of concern appears in the **Client Concerns and Goals** section.
 - Select the **Delete** (bin) icon to remove the area of concern.
 - Select the **Edit** (pencil) icon to update the area of concern.

Client concerns and goals

ADD AREA OF CONCERN

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

4. To add a goal for the area of concern, select **ADD A GOAL**.

Client concerns and goals

ADD AREA OF CONCERN

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

ADD A GOAL

In the pop-up window, enter the goal, record the client's motivation to achieve it on a scale of **1 to 10** (where **1** is least motivated and **10** is most motivated), select the goal status, and then select **SAVE TO PLAN**.

Add goal

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

What is the client's goal? *

To be able to perform household tasks

Most relevant domain that goal area relates to?

☒ Physical function ☐ Cognitive function ☐ Social support
☒ General health ☒ Personal health ☐ Home and personal safety
☐ Other

What are the client's current areas of difficulty or activities where the client needs support in order to achieve this goal? *

Difficulty in lifting light to heavy objects, Difficulty with mobility and long time standing

What are the client's current strengths and abilities in relation to this goal? *

Can sit and stand for a limited period of time

SAVE TO PLAN CANCEL

5. The goal appears under the relevant area of concern in the **Client Concerns and Goals** section.

- Select the **Edit** (pencil) icon to update the goal.
- Select the **Delete** (bin) icon to remove the goal if it is no longer relevant.

Client concerns and goals

ADD AREA OF CONCERN

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

ADD A GOAL

Goal: To be able to perform household tasks

6. To add more areas of concern and goals, repeat the previous steps.

! Changing the Display Order of Areas of Concern or Goals

If you have added multiple areas of concern or goals, you can change the order in which they appear.

Use the drop-down list on the right side of the area of concern or goal, and select the required position. The system updates the display order accordingly.

Client concerns and goals

ADD AREA OF CONCERN

Concern: To be more active in everyday life.

ADD A GOAL

Goal: To go to the gym twice per week.

Concern: Collin's injuries are preventing him from enjoying his usual hobbies, such as gardening.

ADD A GOAL

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

- You can also add service recommendations to help the client achieve their goals.

Select the **Expand** icon next to the relevant goal.

Select the appropriate recommendation button.

For more information, refer to [Adding Recommendations](#).

Goal: To be able to perform household tasks

Most relevant domain that goal area relates to:

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

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

Can sit and stand up without help for sometime

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

Difficulty with mobility

Focus of the goal for the client:

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

Motivation to achieve: 8

Status: In Progress

Recommendations

Add to this goal:

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

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

Linking Goals to Existing Support at Home Recommendations

Assessors can link goals in the support plan to existing Support at Home service recommendations.

- On the client's **Support Plan and Services** screen, select the **Goals & Recommendations** tab and go to the **Client Concerns and Goals** section.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 1
 Recommended classification: SaH Classification 4 Agreed
 HM Medium
 Specified needs - Continence Products

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

Client concerns and goals

ADD AREA OF CONCERN

Concern: Difficulty in cooking

ADD A GOAL

Goal: Ability to cook

2. Select the **Expand** icon next to the relevant goal, then select **LINK TO EXISTING SAH RECOMMENDATIONS**.

Goal: Ability to cook

Most relevant domain that goal area relates to:

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

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

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

Focus of the goal for the client:

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

Motivation to achieve: 6
 Status: In Progress

Recommendations

Add to this goal:

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

LINK TO AN EXISTING RECOMMENDATION **LINK TO THE EXISTING SAH RECOMMENDATIONS**

3. The **Link to Existing SaH Recommendations** screen opens.
- Select a recommendation (classification) from the drop-down list.
 - Select the **Expand** icon to view the available service types.
 - Select the checkbox next to each service you want to link to the goal.
 - Select **SAVE TO PLAN**.

Link to the existing SaH recommendations

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

Select a recommendation *
SaH Classification 4

Select the services to be linked to this goal:

- ☒ Care management
- ☐ Domestic assistance
- ☐ Home maintenance and repairs
- ☐ Home or community general respite

☒ Meals

- ☐ Meal delivery
- ☒ Meal preparation
- ☐ Meal delivery
- ☐ Meal preparation
- ☒ Meal delivery
- ☐ Meal preparation
- ☐ Meal delivery

SAVE TO PLAN

CANCEL

4. The linked Support at Home recommendation appears under the relevant goal in the **Client Concerns and Goals** section.

Goal: Ability to cook

Most relevant domain that goal area relates to:

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

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

Can move and walk

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

Lifting objects and cutting vegetables

Focus of the goal for the client:

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

Motivation to achieve: 6

Status: In Progress

Support at Home recommendations:

SaH Classification 4

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

Recommendations

Add to this goal:

ADD A GENERAL RECOMMENDATION

ADD A SERVICE RECOMMENDATION

ADD AN ASSISTIVE TECHNOLOGY

LINK TO THE EXISTING SAH RECOMMENDATIONS

Recording Service Frequency and Intensity

You can record the recommended frequency and intensity for each service you recommend. This is optional.

Record any information discussed with the client, including their preferences for how often they would like to receive the service and the level of support they need. Service providers can use this information as a guide when agreeing on service frequency and intensity with the client.

If a client does not want to access a service immediately, or only needs it occasionally, you should still create the service recommendation. The client can access the service later by contacting the **My Aged Care Contact Centre**, which can arrange electronic referrals from recommendations already included in the client's support plan.

Providing details about the recommended services helps service providers and Contact Centre staff understand whether a service is needed for a specific purpose or as ongoing support.

This information also helps the Contact Centre determine whether it can make a referral directly or whether it needs to request a **Support Plan Review** from the assessment organisation.

Add service recommendation

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

Service Type: *

Priority and dates

Priority: *

Low

Recommended service frequency ?

Recommended service intensity ?

Recommend a start date

☐ Yes ☒ No

Recommend a review date

☐ Yes ☒ No

Recommend an end date

☐ Yes ☒ No

Responsibility to action

☐ Assessor ☐ Client ☐ Other

Comments:

0 / 100

Associated goals

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

UNLINK THIS RECOMMENDATION FROM ALL GOALS

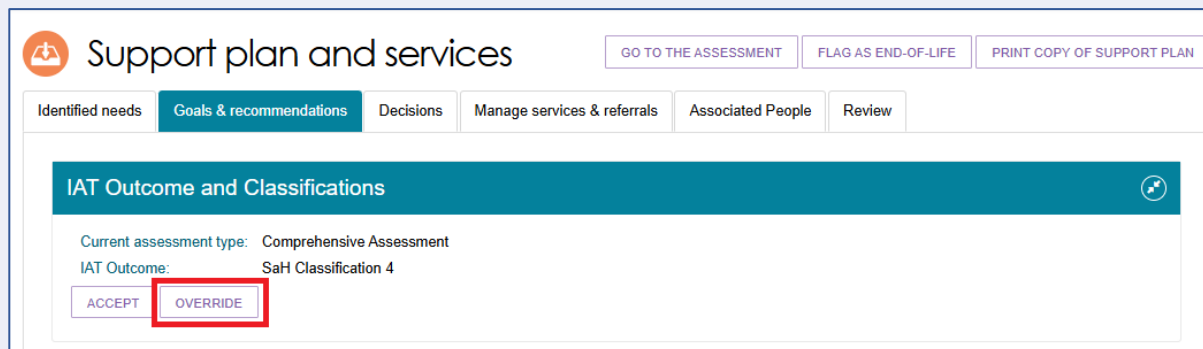
SAVE TO PLAN CANCEL

Support at Home - Restorative Care Pathway

Overriding to Restorative Care Pathway

After a client receives an IAT outcome, you can override the outcome to the **Support at Home (SaH) Restorative Care Pathway**.

1. Go to the client's **Support Plan** and select the **Goals & Recommendations** tab, and Select **OVERRIDE**.



Support plan and services

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

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

IAT Outcome and Classifications

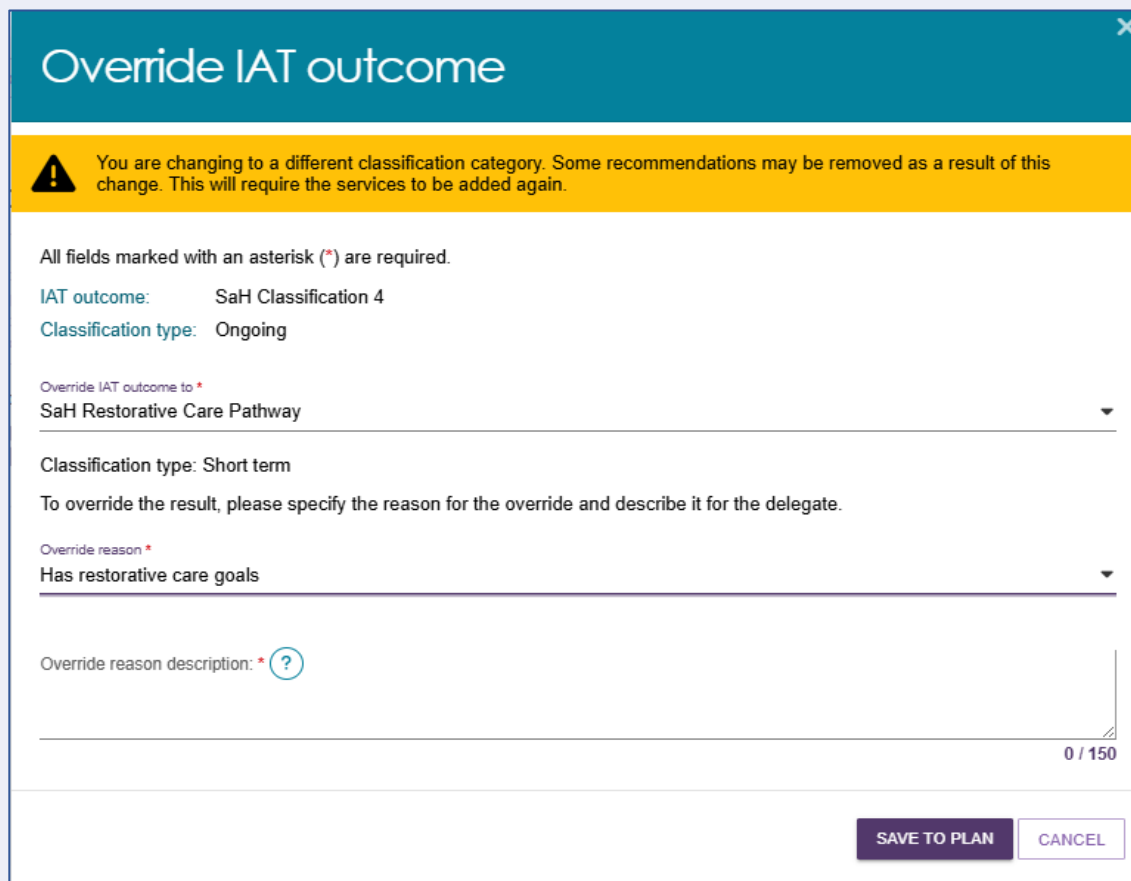
Current assessment type: Comprehensive Assessment

IAT Outcome: SaH Classification 4

ACCEPT OVERRIDE

2. The **Override IAT Outcome** pop-up window opens.
 - In **Override IAT Outcome To**, select **SaH Restorative Care Pathway**.
 - Select an override reason.
 - Enter a description of the reason for the override.
 - Select **SAVE TO PLAN**.

The system may display a warning message advising you to review and add recommended services again.



Override IAT outcome

! 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.

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 *

Has restorative care goals

Override reason description: * ?

0 / 150

SAVE TO PLAN CANCEL

- If the original IAT outcome was a **Support at Home classification**, review the list of Home Support services and select **SAVE TO PLAN**.

The system may display the following message: "Your request is being processed and may take up to 60 seconds. Once processing finishes, you will see the services updated on the screen."



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

- The **Goals & Recommendations** page displays again. Return to the **IAT Outcome and Classification** section to view the updated outcome.

Support plan and services

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

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: SaH Classification 4
Recommended classification: SaH Restorative Care Pathway
 Override reason: Has restorative care goals
 Override reason description: Override reason goes here

If you overrode a Support at Home classification, the classification now displays as **SaH Restorative Care Pathway**.

Recommend that the client receive
Home support
 (not yet in place)
 This recommendation requires a delegate decision
Classification: SaH Restorative Care Pathway
Classification type: Short-term
Home support services: Domestic assistance: General house cleaning, Laundry services, Shopping assistance
 Home maintenance and repairs: Assistance with home maintenance and repairs, Expenses for home maintenance and repairs, Gardening
 Home or community general respite: Community and centre-based respite, Flexible respite
 Meals: Meal delivery, Meal preparation
 Nursing care: Enrolled nurse clinical care, Nursing assistant clinical care, Nursing care consumables, Registered nurse clinical care
 Nutrition: Nutrition supports

- After you accept the classification or recommendation, the **Add Home Support Services** screen opens.
 - Enter the required services for each available service type.
 - Record the recommended frequency and intensity for each service.
 - The **Home Support Restorative Care Management** service is selected by default and cannot be changed.

Restorative care management

Service	Frequency	Intensity
☒ Home support restorative care management		



Editing IAT Outcome to Restorative Care Pathway

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

1. Open the client's support plan from the **Client Record**, **Current Assessments**, or **Recent Assessments** tab.
2. On the **Goals & Recommendations** tab, select **Edit Classification**. The **Edit Recommended Classification** window opens.
3. In the **Override IAT Outcome To** drop-down list, select **SaH Restorative Care Pathway**.
An information message advises that adding the Restorative Care Pathway automatically includes the AT Medium and HM Medium classifications. You can edit or remove these recommendations if required.
4. In the **Override Reason** drop-down list, select one of the following reasons:
 - Has restorative care goals
 - Delay/prevent ongoing services
 - Needs early intervention care
 - Other.
5. Enter the reason for the override in the **Override Reason Description** field. Then select **SAVE TO PLAN**.

×

Edit recommended classification

i

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

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

IAT outcome:

SaH Classification 3

Recommended Classification:

SaH Classification 4

Classification type:

Ongoing

New recommended classification *

SaH Restorative Care Pathway

Classification type: Short-term

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

Override reason *

Other

Please select...

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

Override reason description *

?

0/150

SAVE TO PLAN

CANCEL

Recommending Second Unit of Restorative Care Pathway

If a client has an approved and active **Support at Home (SaH) Restorative Care Pathway** in their support plan, you can recommend a second unit of Restorative Care Pathway within 16 weeks of the first unit starting.

Before recommending or approving a second unit, confirm that the client has started receiving services under the first Restorative Care Pathway unit.

! Do not approve a second unit if the client has not started using their first Restorative Care Pathway unit.

If a delegate approves the second unit, the system creates a new Restorative Care Pathway approval. The approval start date is the date of delegate approval, and the approval end date matches the end date of the first unit.

You can remove the second unit recommendation if circumstances change.

1. Go to the **Support Plan and Services** section and select the **Goals & Recommendations** tab.

Under **IAT Outcome and Classifications**, confirm that the existing classification is **SaH Restorative Care Pathway**.

Select **ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY**.

2. A new window opens. Select **ADD SECOND UNIT** to confirm the recommendation.

The system then begins the process to create the **RCP - Approval of Second Unit of Funding** recommendation.

3. If you need to withdraw the recommendation, select **REMOVE SECOND UNIT OF RESTORATIVE CARE PATHWAY**.

The screenshot shows the 'Support plan and services' interface. The 'IAT Outcome and Classifications' section is active. It displays 'Current assessment type: Comprehensive Assessment' and 'IAT Outcome: SaH Classification 3'. A red box highlights the button labeled 'REMOVE SECOND UNIT OF RESTORATIVE CARE'. Below this, the 'Client concerns and goals' section has an 'ADD AREA OF CONCERN' button and a message 'No client concerns or goals.' The 'Other recommendations' section includes buttons for 'ADD A GENERAL RECOMMENDATION', 'ADD A SERVICE RECOMMENDATION', 'ADD RECOMMENDED LONG TERM LIVING ARRANGEMENT', and 'ADD NO CARE TYPE UNDER THE'. A recommendation for 'Home Support' is shown with a date of '6 May 2025'. At the bottom, there are buttons for 'SAVE AND SUBMIT FOR DELEGATE DECISION' and 'RETURN TO CLIENT', and a green confirmation message: 'Successfully added second unit of Restorative Care Pathway.'

In the confirmation window, select **REMOVE**.

The screenshot shows a confirmation window titled 'Remove second unit of Restorative Care Pathway'. The text inside reads 'Remove second unit of Restorative Care Pathway for Sergio MAY.' At the bottom right, there are two buttons: 'REMOVE' (highlighted with a red box) and 'CANCEL'.

End-of-Life Pathway

This section explains how to edit and override IAT outcomes to include the **End-of-Life (EoL) Pathway**.

For clients starting a new [Support Plan Review for services following an EoL episode](#), refer to the relevant section of [Support Plan Reviews](#).

! Before you recommend or approve the End-of-Life Pathway, you must:

- Flag the client as **End-of-Life** in the My Aged Care assessor portal.
- Validate the client's **End-of-Life Pathway form** in accordance with the current process described in the **Assessment Manual**.

You can complete these actions during the client's assessment, from the client record, or during a Support Plan Review

On the Support Plan and Services page

In the Client Card

Validating the End-of-Life Form

Assessment delegates must confirm that the End-of-Life Pathway form has been completed correctly when the client has been flagged as End-of-Life in the My Aged Care assessor portal.

When reviewing the form, you must:

- Confirm that the client's details match the information recorded in the assessor portal.
- Check that all sections of the **Medical Assessment** have been completed. Confirm that:
 1. The client has a life expectancy of **three months or less**.
 2. The client has an **Australian-modified Karnofsky Performance Status (AKPS)** score of **40 or less**.
 3. A medical practitioner or nurse practitioner has completed and signed the form.

A client is not eligible for approval under the **End-of-Life Pathway** unless all required

criteria in the **Medical Assessment** section have been met.

Overriding to End-of-Life Pathway

Before you can override an IAT outcome to the **End-of-Life (EoL) Pathway**, you must first flag the client as **End-of-Life**.

1. Open the client's support plan.
Search for the client, or
Open the client's record, select the **Plans** tab, and then select **Support Plan**.
2. Select the **Goals & Recommendations** tab, then choose **OVERRIDE TO END-OF-LIFE** or **Edit Classification**.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH Restorative Care Pathway
 IAT Outcome: SaH Classification 2 SaH Restorative Care Pathway (Second Unit)
 SaH Classification 2 (Pending allocation)

OVERRIDE TO END-OF-LIFE

3. The **Override IAT Outcome** window opens.

An information message advises that overriding to the End-of-Life Pathway automatically adds the **AT Medium** classification to the client's support plan. You can edit or remove this recommendation if required.

Any Home Modification recommendations will be removed when you override to the End-of-Life Pathway.

Override to End-of-Life Pathway

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

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

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

Existing Classification: SaH Classification 2
Classification type: Ongoing

Override existing classification to *
SaH End-of-Life Pathway

Classification type: Short term

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

Override reason *

Override reason description: * ?

0 / 150

OVERRIDE **CANCEL**

4. Select an **Override Reason** from the drop-down list and enter a description of the reason for the override. Select **OVERRIDE**.

Override reason *

Please select...

Please select...

Higher level service needs

Lower level service needs

Other Aged Care Program/s

No Care Approval

0 / 150

Override reason *

Higher level service needs

Override reason description: * ?

Override reason description here

32 / 150

OVERRIDE **CANCEL**

5. If the override is successful, the **IAT Outcome and Classifications** section displays:
- **SaH End-of-Life Pathway**
 - The override reason
 - The override reason description

If applicable, **REVERT** buttons may appear, allowing you to return the client to their previous classification.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

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

IAT Outcome: SaH Classification 2 SaH Restorative Care Pathway (Second Unit)

Recommended classification: SaH End-of-Life Pathway SaH Classification 2 (Pending allocation)

AT Medium

Override reason: Higher level service needs

Override reason description: Override reason description here

[REVERT TO ONGOING SAH CLASSIFICATION](#) [REVERT TO RESTORATIVE CARE](#)

6. Review the client's Home Support services and [update them if required](#) to align with the End-of-Life Pathway.

To edit the services, select the **Edit** (pencil) icon in the **Home Support** recommendation under the **Other Recommendations** section.

Recommend that the client receive **Home support**

(not yet in place)

This recommendation requires a delegate decision

Classification: SaH End-of-Life Pathway

Classification type: Short-term

Home support services:

Recommended by: My Agedcare Contact Centre

[SAVE AND SUBMIT FOR DELEGATE DECISION](#) [RETURN TO CLIENT](#)

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

If a client has been flagged as **End-of-Life**, you can change their classification to **SaH End-of-Life Pathway** when:

- The current classification is **SaH Restorative Care Pathway**.
- The **End-of-Life Pathway** form has been verified.
- You have not yet submitted the **Support Plan Review** for delegate decision.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

[OVERRIDE TO END OF LIFE](#) [ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY](#)

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

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

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

2. Review the information in the recommendations section, then select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW**.

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

Recommended by: Damien Wayne

COMPLETE AND FINALISE SUPPORT PLAN REVIEW | RETURN TO CLIENT

3. The **IAT Outcome and Classifications** section updates to show **SaH End-of-Life Pathway** as the recommended classification.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT outcome: SaH Classification 3

Recommended classification: SaH End-of-Life Pathway

REVERT TO RESTORATIVE CARE

Existing classification: SaH Restorative Care Pathway

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

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

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

Recommended by: Damien Wayne

SAVE AND SUBMIT FOR DELEGATE DECISION | RETURN TO CLIENT

! If the client or their supporter guardian decides they no longer want the assessment flagged as **End-of-Life**, you can [revert the classification](#) to the client's ongoing classification.

5. Complete the Support Plan Review details:

- Select the review outcome from the drop-down list.
- Record who participated in the plan review.

Select **COMPLETE AND FINALISE SUPPORT PLAN REVIEW** to finalise the review.

After you complete the Support Plan Review, you cannot edit the outcome details. The system records these details in the client's support plan.

Complete & finalise support plan review for First Name LAST NAME

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

Outcome of support plan review *

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

Support plan conducted with *

COMPLETE & FINALISE SUPPORT PLAN REVIEW CANCEL

! If you add a period of **reablement** or **linking support** during a Support Plan Review, the system automatically sets the review outcome to **Updates to Existing Plan**. After you complete the review, the assessment remains open so you can start the support period.

! If the Support Plan Review identifies the need for a new assessment, refer to [Issuing an assessment referral as a result of a Support Plan Review](#).

6. The completed Support Plan Review appears on the **Plans** tab of the client's record.

View support network

Plans

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

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

Recommendations

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

Upcoming Review(s)
No upcoming reviews scheduled

Assessment history

- Comprehensive Assessment 16 August 2023
- Home Support Assessment 26 September 2020
- Screening 18 September 2020

Plan history

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

Review history

- Review 2 May 2025

Reablement and linking support history

Revert End-of-Life Flag

If the client or their supporter guardian decides they no longer want the assessment flagged as **End-of-Life**, you can revert the classification to the previous ongoing recommendation.

1. Open the client's profile and select the Goals & Recommendations tab.
2. In the **IAT Outcome and Classifications** section, confirm that the recommended classification is **SaH End-of-Life Pathway**. Select the **REVERT** button for the previous classification. For example, **REVERT TO RESTORATIVE CARE**.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH

IAT outcome: SaH Classification 3

Recommended classification: SaH End-of-Life Pathway

REVERT TO RESTORATIVE CARE

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

3. In the confirmation window, select **REVERT**.

Revert to Restorative Care Pathway

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

REVERT **CANCEL**

4. After you confirm the action, the system returns you to the **Goals & Recommendations** tab and restores the previous classification.

Support plan and services

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

IAT Outcome and Classifications

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

IAT outcome: SaH Classification 3

Recommended classification: SaH Restorative Care Pathway

OVERWRITE TO END OF LIFE **ADD SECOND UNIT OF RESTORATIVE CARE PATHWAY**

Client concerns and goals

Overriding a Transitioned HCP Classification to the End-of-Life Pathway

After the End-of-Life Pathway form has been verified, you can override a client's classification from **Transitioned HCP Level 1-4** to **SaH End-of-Life Pathway** during a Support Plan Review.

Transitioned clients do not have pre-created services. You need to add Home Support services that meet the client's end-of-life care needs.

1. Open the client's profile and select the **Goals & Recommendations** tab.

In the **IAT Outcome and Classifications** section, confirm that the existing classification is **Transitioned HCP Level 1-4**.

Select **OVERRIDE TO END OF LIFE**.

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Home Support Assessment

IAT outcome: HCP

Existing classification: Transitioned HCP Level 2

OVERRIDE TO END OF LIFE

2. The **Override to End-of-Life Pathway** window opens. Enter the required information and select **OVERRIDE**.

Override to End-of-Life Pathway

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

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

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

Existing Classification: Transitioned HCP Level 2

Classification type: Ongoing

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

Override existing classification to *

SaH End of Life Pathway

Classification type: Short-Term

Override reason *

Higher level service provision needs

Override reason description *

0/100

OVERRIDE CANCEL

3. The **Add Home Support Services** screen opens.

Consider the client's needs and the End-of-Life Pathway approval when selecting services.

- Select the required services.
- Enter the recommended frequency and intensity for each service.
- Link any relevant goals.

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

Add Home Support services

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

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

Linked goals

Please select services within each service type *

Domestic Assistance

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

Home maintenance and repairs

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

4. Select **SAVE TO PLAN**.

☒ Nursing care consumables

Frequency Intensity Linked

Allied health and therapy

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

SAVE TO PLAN CANCEL

5. The system returns you to the **Goals & Recommendations** tab.

At this stage, you can revert to the transitioned classification if required.

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

Support plan and services

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: Transitioned HCP Level 2
 IAT outcome: HCP
 Recommended classification: SaH End-of-Life Pathway
REVERT TO TRANSITIONED CLASSIFICATION

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

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

Recommended that the client receive
Home Support
 (Not yet in place)
 This recommendation requires a delegate decision
 Classification: SaH End-of-Life Pathway Classification type: Short term
 Home support services: @
 Recommended by: Damien Wayne

SAVE AND SUBMIT FOR DELEGATE DECISION | RETURN TO CLIENT

! If the client's current classification is **SaH End-of-Life Pathway**, you can override it back to **Transitioned HCP Level 1-4** before submitting the support plan for delegate decision.

After you complete the override, you can also revert back to **SaH End-of-Life Pathway** if required.

Support plan and services

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

IAT Outcome and Classifications

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

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

ADD A GENERAL RECOMMENDATION | ADD A SERVICE RECOMMENDATION

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

After you override an **End-of-Life Pathway** classification to a **Transitioned HCP** classification, you can revert the client back to the **End-of-Life Pathway** if needed.

1. Go to the client's **Goals & Recommendations** tab.

In the **IAT Outcome and Classifications** section, confirm that the existing classification is **SaH End-of-Life Pathway**. Select **REVERT TO END OF LIFE**.

Support plan and services

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

IAT Outcome and Classifications

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

IAT outcome: HCP

Recommended classification: Transitioned HCP Level 2

REVERT TO END OF LIFE

2. A confirmation window opens. Select **REVERT** to confirm the change.

Revert to End-of-Life Pathway

Revert to End-of-Life Pathway for First Name Last Name

REVERT CANCEL

3. The system returns you to the **Goals & Recommendations** tab with the End-of-Life Pathway classification restored.

Support plan and services

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

IAT Outcome and Classifications

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

IAT outcome: HCP

OVERRIDE TO TRANSITIONED CLASSIFICATION

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

Completing the Support Plan

Follow these steps to complete and submit the support plan:

1. Review the support plan and confirm that:

- [All required service and general recommendations have been added.](#)
- The client's [goals and areas of concern](#) are accurate and complete.

After you complete the support plan, you cannot edit it unless the [delegate returns the assessment for changes](#).

2. Select **COMPLETE SUPPORT PLAN** from any tab within the client's support plan.
3. If the client has a **Support at Home** classification (ongoing or short-term) but does not have a recorded home address or [Modified Monash Model \(MMM\) classification](#), the system displays a reminder to record the client's address.
You can still proceed without recording the address at this stage by selecting **CONTINUE TO COMPLETE SUPPORT PLAN**.

- ! If you continue without recording the client's home address, the system displays the following warning message:

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

4. If the client's address has been recorded but the system cannot determine an **MMM classification (MMM1 to MMM7)**, you must update the client's MMM classification before completing the support plan.

If the MMM classification is not known, select **UNKNOWN** from the drop-down list.

Update client's MMM classification

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



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

MMClassification: * (?)

Unknown

Select one

MM1 Metropolitan areas

MM2 Regional centres

MM3 Large rural towns

MM4 Medium rural towns

MM5 Small rural towns

MM6 Remote communities

MM7 Very Remote communities

Unknown

5. Select **SAVE TO PLAN**.

Update client's MMM classification

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



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

MMClassification: * (?)

Unknown

SAVE TO PLAN

CANCEL

6. The system takes you to the **Decisions** tab. Scroll to the bottom of the page and select **SAVE AND SUBMIT FOR DELEGATE DECISION**.

SAVE AND SUBMIT FOR DELEGATE DECISION

RETURN TO CLIENT

7. In the confirmation window, select the appropriate checkbox and then select **SUBMIT**.

Submit for Delegate decision

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

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

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

SUBMIT

CANCEL

8. A confirmation message appears, advising that the assessment and support plan have been submitted to the delegate for review and decision.



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



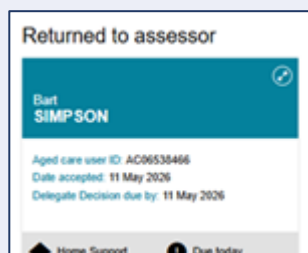
'Returned to Assessor' status

A delegate may return a **Support Plan Review** or **IAT assessment** if changes are needed. When this happens, the assessment status changes to **Returned to Assessor**.

Amendments to the IAT

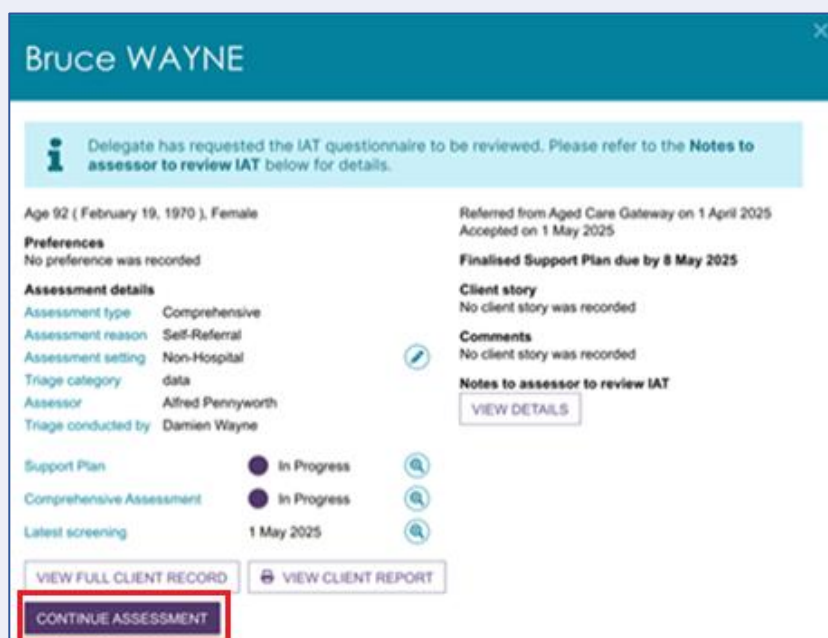
If a delegate identifies issues with the IAT, they may return the assessment and provide instructions for the required changes. A delegate can return an assessment to an assessor only once.

You can view returned assessments on the **Assessments** tab under **Returned to Assessor**.



When an IAT assessment is returned, the client record displays:

- An information banner advising that the delegate has requested a review of the IAT and directing you to the delegate's notes for further instructions.
- A **Notes to Assessor to Review IAT** section containing the delegate's feedback.
- A **View Details** button to open the delegate's notes.
- A **Continue Assessment** button that opens the IAT so you can make the requested changes.



You can also view the delegate's request from the client's **Support Plan and Services** page on the **Goals & Recommendations** tab.

An information banner appears in the **IAT Outcome and Classifications** section. Select **Go to Assessment** to open the IAT and make the requested changes.

 Support plan and services

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

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

IAT Outcome and Classifications

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

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

To review the delegate's feedback, open the **Notes to Assessor to Review IAT** window. This window displays instructions and comments for the relevant IAT sections that require amendment.

Notes to assessor to review IAT

Notes to assessor:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLOSE

Reviewing and Resubmitting the returned IAT

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

1. Go to the **Assessments** tile in the Assessor Portal. Open the client's assessment from the **Current Assessments** tab under **Returned to Assessor**.

Current assessments Currently viewing Aussie Healthcare

Current assessments Recent assessments

Filter by

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

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

Returned to assessor

First Name LAST NAME	First Name LAST NAME	First Name LAST NAME
SUBURB, STATE, 1111 Aged care user ID: ACXXXXXXXXX1 Date accepted: DD Month Year Completed Support Plan due by: DD Month Year Comprehensive 145 days overdue Assessment In Progress High	SUBURB, STATE, 1111 Aged care user ID: ACXXXXXXXXX1 Date accepted: DD Month Year Completed Support Plan due by: DD Month Year Comprehensive 8 days overdue Assessment In Progress Medium	Assessor: First Name Last Name Delegate: First Name Last Name Aged care user ID: ACXXXXXXXXX1 Delegate Decision due: DD Month Year Comprehensive 8 days overdue Assessment In Progress Medium

2. Review the delegate's feedback by selecting **View Details** in the **Notes to Assessor to Review IAT** section on the client card.

First Name LAST NAME

Please confirm that , 1 June 1948, 78 Years, AC5555555 is the person you are conducting this assessment for. If the person details are incorrect, a privacy breach may occur.

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

Aged 78 (1 June 1948), Male Referred from Aged Care Gateway on 4 February 2026
Accepted on 5 February 2026

Preferences
No preference was recorded

Assessment details
Assessment type: Home Support
Assessment reason: the client is eligible for CHSP
Assessor: First Name Last Name
Triage conducted by: First Name Last Name

Support plan
Home Support Assessment: In Progress
Latest screening: 4 February 2026

Finalised Support Plan due by 26 February 2026

Client story
No client story was recorded

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

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

[CONTINUE ASSESSMENT](#)

Alternatively, open the client's **Support Plan and Services** page, select the **Goals & Recommendations** tab, and then select the **Notes to Assessor to Review IAT** link in the information banner within the **IAT Outcome and Classifications** section.

3. The **Notes to Assessor to Review IAT** window opens and displays:

- The relevant IAT topics.
- The delegate's comments and instructions for each topic.

Review the instructions and identify the changes you need to make.

Select **Close** and then:

- Select **Continue Assessment** from the client card, or
- Select **Go to Assessment** from the **Support Plan and Services** page.

4. Review the IAT and make the requested changes.

When a delegate returns an IAT:

- The system clears all review checkboxes, including page review checkboxes.
- The system clears the **Goals Review** button.
- You must complete all mandatory questions again and reselect all review checkboxes before finalising the IAT.

After you re-finalise the assessment, the delegate cannot return the IAT for review again.

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

5. Once you finalise the IAT, the client's IAT outcome may change.

The system may display the following message: **Please revise the Recommended Classification and Support Plan recommendations based on the new IAT Outcome.**

Support plan and services

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

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

IAT Outcome and Classifications

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

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

Review:

- The recommended classification.
- Any related prompts or recommendations, such as Restorative Care Pathway, Assistive Technology, or Home Modifications.

If you intend to recommend an ongoing Home Support classification, make sure the **Recommended Classification** matches the new **IAT Outcome** by using the edit function.



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

If the new IAT outcome results in a lower classification than the client's existing classification, ensure the **Recommended Classification** remains equivalent to the client's current classification when recommending ongoing Home Support services through Support at Home or CHSP.

If appropriate, you can still override the **Recommended Classification** to recommend a short-term pathway or Residential Care.

Edit recommended classification

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

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

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

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

6. Review and update the client's support plan if required to reflect the new IAT outcome and recommendations.

When you finish reviewing the classification and support plan, select **COMPLETE SUPPORT PLAN**.

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

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

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

 Recommend that the client receive **Home support** 

 Recommend that the client receive **Home modifications** 

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

7. The **Note to Delegate** window opens.

Enter details of the changes you made in response to the delegate's feedback.

- The **Notes to Delegate** field is mandatory.
- The field includes a pre-filled list of IAT domains for reference. You can edit or remove this text as required.
- Non-clinical assessors must record all clinical supervisors involved in the assessment process.

If you leave the field blank, the system displays an error message.

Select **CONTINUE TO COMPLETE SUPPORT PLAN**.

Note to delegate

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

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

Notes to delegate: *

Assessment Details:

Reason for Assessment:

Carer profile:

Medical and Medications: Amended this section

Function:

Physical, Personal Health & Frailty:

Social:

Cognition: Added latest test results

Behaviour:

Psychological:

Home & Personal Safety:

Financial or Legal:

Support Considerations:

Validated Assessment Tools:

Other: Clinical Supervisor is Jane Doe

374 / 2500

CONTINUE TO COMPLETE SUPPORT PLAN **CANCEL**

8. After completing all required changes, select **SAVE AND RESUBMIT FOR DELEGATE DECISION**.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

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

RECOMMEND AN ASSISTIVE TECHNOLOGY

SAVE AND RESUBMIT FOR DELEGATE DECISION RETURN TO CLIENT

In the confirmation window, select **SUBMIT**.

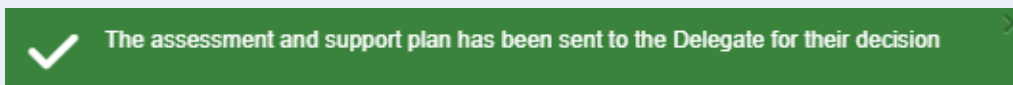
Submit for Delegate decision

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

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

SUBMIT CANCEL

9. If the resubmission is successful, the system displays a confirmation message advising that it has submitted the assessment to the delegate.



An information banner also appears stating that the assessor has reviewed the IAT as requested by the delegate.



Select the **here** link in the banner to view both:

- Your **Notes to Delegate**, and
- The delegate's **Notes to Assessor**.

Notes to delegate on the IAT review

Notes to delegate:

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

Notes to assessor:

CLOSE

Amendments to the support plan

After you complete the IAT assessment, finalise the support plan, and submit your recommendations for delegate decision, the delegate may return the **Comprehensive Assessment** or **Home Support Assessment** if changes are required to the support plan.

Returned assessments appear in the **Returned to Assessor** section of the **Assessments** tab.

The screenshot shows two assessment cards. The top card, titled 'Triage Not Started', has a blue header with 'First Name' and 'LAST NAME'. Below the header, it shows a location pin icon followed by 'SUBURB, STATE, 1111', 'Aged care user ID: ACXXXXXXXXX1', 'Date accepted: DD Month Year', and 'Completed Triage due by: DD Month Year'. It features two status bars: a grey one with a pencil icon, 'Comprehensive', and '84 days overdue'; and a red one with an exclamation mark icon, 'Triage Not Started', and 'High'. The bottom card, titled 'Returned to assessor', has a similar blue header. It shows 'Aged care user ID: ACXXXXXXXXX2', 'Date accepted: DD Month Year', and 'Delegate Decision due by: DD Month Year'. At the bottom, it has a blue bar with a house icon, 'Home Support', and a red bar with an exclamation mark icon, 'Due today'.

When a delegate returns an assessment, review the instructions provided and make the required updates. Depending on the delegate's feedback, you can amend:

- Client concerns and goals
- Service recommendations
- Other recommendations
- The assessment summary

For detailed guidance on amending a returned assessment, refer to the [Assessment Manual](#).

Finalising the support plan

After you complete the assessment and support plan, arrange referrals for the recommended services before you finalise the support plan.

For detailed instructions refer to [My Aged Care – Assessor Portal User Guide 8 – Referring for services](#).

! Finalise the client's support plan after you have made an effective referral for the recommended services, or when the client chooses not to proceed with aged care services or wants to manage their own referrals.

A referral is considered effective when:

- A service provider accepts the referral.
- The client chooses to manage their own referral arrangements.
- The assessment determines that no further action is required from the assessor.

! Do not issue **CHSP referral codes** until the **Assessment Delegate** has approved the recommendation.

For instructions on issuing CHSP referral codes, refer to:

- *Chapter 9: Finalising the Assessment and Service Referral* of [My Aged Care Assessment Manual](#).
- instructional videos for **comprehensive** and **home support assessments**.

1. From any tab in the client's support plan, select **FINALISE SUPPORT PLAN**.

2. A confirmation window opens.
 - The system automatically displays the referral status for each recommended service type.
 - If a referral has a status of **Not Actioned**, you must record a reason.
3. If you conducted the face-to-face assessment in a remote location, make sure you select the **Remote Assessment** indicator before finalising the support plan.

Review the referral outcomes and select **YES, FINALISE THE SUPPORT PLAN**.

! If you are recording outcomes for a client in a remote location, you can select **Community-based Care** as the outcome.

You must enter comments about the outcome if you select either **Not Actioned** or **Community-based Care** following a remote assessment.

Provide clear and detailed comments to explain the reason for the selected outcome.

4. The system displays a confirmation message advising that the support plan has been finalised.

Finalising a Support Plan for Support at Home classification

When you finalise a support plan that includes a recommended Support at Home classification, the screen does not display individual services for outcome recording. Instead, it displays a single item called **Support at Home**.

Select **YES, FINALISE THE SUPPORT PLAN** to finalise the support plan.

Finalise support plan

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

☐ Remote Assessment ?

Service Recommendations

Support at Home

Outcome
Not actioned

Outcome Reason *

Comments

YES, FINALISE THE SUPPORT PLAN NO, CANCEL

Ending a period of Reablement or linking support

You can end a reablement or linking support period in one of two ways:

Option 1: End a support period individually

1. On the **Goals & Recommendations** tab of the client's support plan, select **END LINKING SUPPORT PERIOD** or **END REABLEMENT PERIOD**.
2. Enter the support period **end date** and **outcome**.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

There are no service recommendations for this client

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

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

3. If you want to finalise the support plan but keep the support period open, select **FINALISE SUPPORT PLAN & KEEP OPEN FOR SUPPORT PERIOD**.

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT outcome

IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals
No client concerns or goals.

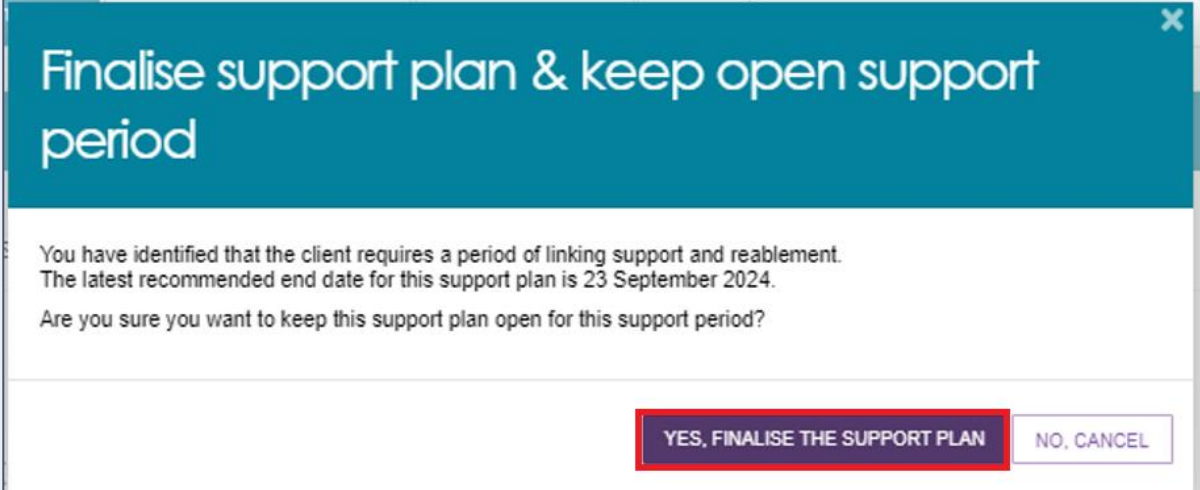
Other recommendations
There are no service recommendations for this client

Recommend that the client receive Linking Support

Recommend that the client receive Reablement

FINALISE SUPPORT PLAN & KEEP OPEN FOR SUPPORT PERIOD RETURN TO CLIENT

4. A confirmation window will appear. Select **YES, FINALISE THE SUPPORT PLAN**.



Finalise support plan & keep open support period

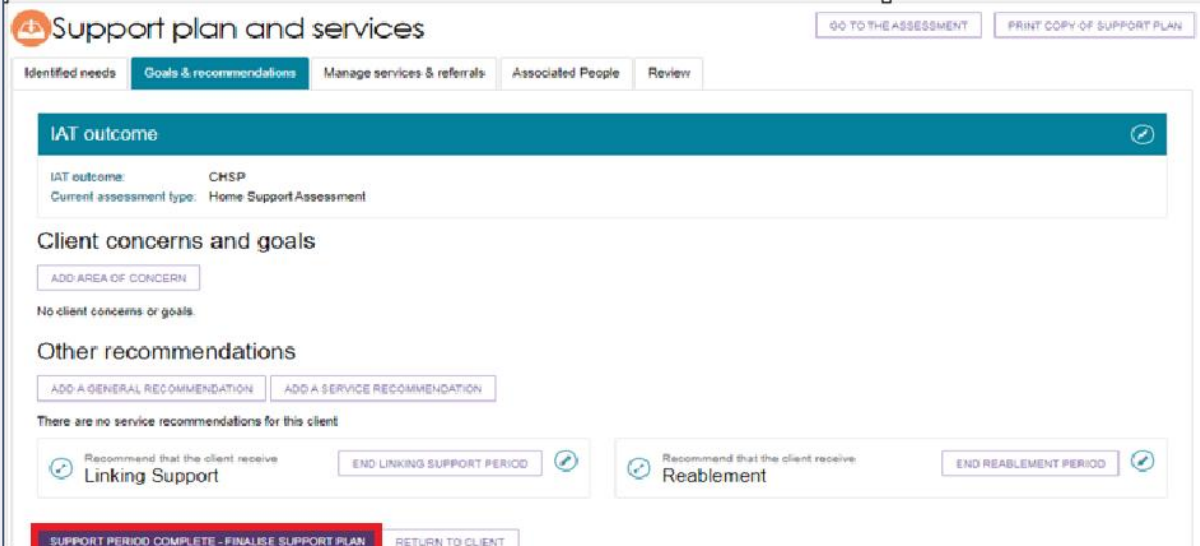
You have identified that the client requires a period of linking support and reablement. The latest recommended end date for this support plan is 23 September 2024.

Are you sure you want to keep this support plan open for this support period?

YES, FINALISE THE SUPPORT PLAN NO, CANCEL

Option 2: End all support periods at the same time

1. On the **Goals & Recommendations** tab of the client's support plan, select **SUPPORT PERIOD COMPLETE – FINALISE SUPPORT PLAN**.



Support plan and services

GO TO THE ASSESSMENT PRINT COPY OF SUPPORT PLAN

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

IAT outcome

IAT outcome: CHSP
Current assessment type: Home Support Assessment

Client concerns and goals

ADD AREA OF CONCERN

No client concerns or goals.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

There are no service recommendations for this client

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

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

SUPPORT PERIOD COMPLETE – FINALISE SUPPORT PLAN RETURN TO CLIENT

2. The system displays all active linking support and reablement periods. Enter an **end date** and **outcome** for each support period.

Ending a Reablement Period

1. Select **END REABLEMENT PERIOD** next to the Reablement tile under **Other recommendations**.

Other recommendations

ADD A GENERAL RECOMMENDATION ADD A SERVICE RECOMMENDATION

Recommend that the client receive
Meals

Recommend that the client receive
Reablement

END REABLEMENT PERIOD

2. The **End period of reablement** window opens.

Complete the two mandatory questions:

- Were the client's reablement goals met?
- What was the outcome of the reablement period?

Select the outcome from the drop-down list.

Mandatory fields are marked with an asterisk (*).

Enter any additional information about the reablement period in the **Comments** field.

End period of reablement

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

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

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

The end date for this reablement period is *

04/12/2018

Were the client's goals met? *

Goals partially met

Outcome of this reablement period *

Incomplete

Comments *

Client entered hospital

23 / 500

END PERIOD OF REABLEMENT CANCEL

! If a client is receiving linking support or reablement, a team leader may ask you to end the support period so they can assign a **Support Plan Review**.

If the support period needs to continue, you can ask the team leader to cancel the review and allow the support period to remain active.

Printing a copy of the support plan

You can print a PDF copy of the client's support plan from the assessor portal.

The PDF includes the client's:

- most recent completed **Support Plan Review** (if available)
- **Assessment Summary**
- **Goals & Recommendations**, including areas of concern
- recommended services
- referral codes, where applicable
- strategies
- current care approvals.

To print the support plan:

1. Select **PRINT COPY OF SUPPORT PLAN** from the client record or support plan.

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

2. A blue banner appears at the bottom of the screen while the report is being generated. Select **Reports** page to open the **Reports and documents** page.

The screenshot shows a blue banner with an information icon on the left. The text inside the banner reads: 'Report is still progressing. To check the status, go to [Reports page](#)'.

3. On the **Reports and documents** page, select **View**.

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

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

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

4. The PDF version of the support plan downloads to your device. You can now print the document.

 Australian Government	 myagedcare	SUPPORT PLAN
Support plan		
Mrs First Name LAST NAME Aged Care ID: AC33333333 Date of Birth: 30/05/1928 Age: 97 years		
About your most recent (support plan review)		
Review Date:	04/02/2026	
Conducted by:	First Name Last Name	
Conducted with:	Client	
Outcome of Review:	Updates to the existing plan	
Outcome Details:		

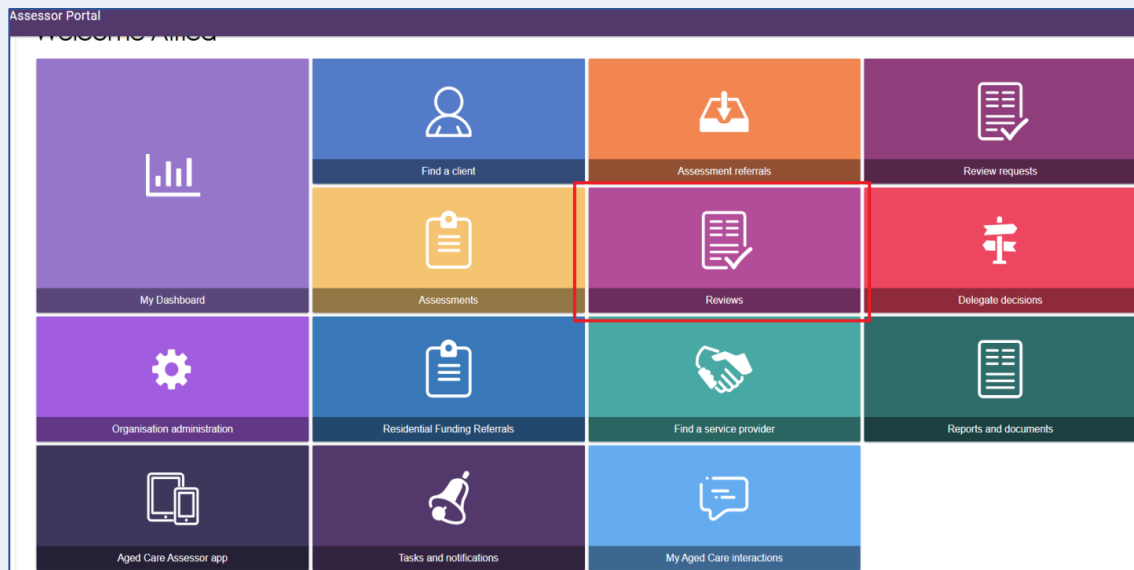
If the client has a previously completed **Support Plan Review**, the **Support Plan Review (first completed)** section appears before the **Goals & Recommendations** section.

 Australian Government	 myagedcare	SUPPORT PLAN
Support plan		
Mr First Name Last Name Aged Care ID: ACXXXXXXXXX1 Date of Birth: DD/MM/YYYY Age: 69 years		
Support Plan Review (first completed)		
Review Date:	DD/MM/YYYY	
Conducted by:	First Name Last Name	
Conducted with:	Client	
Outcome of Review:	Updates to the existing plan	
Outcome Details:		
Your goals and recommendations		
No current concerns, goals or recommendations		
General recommendations		
No current general recommendations		
Your recommended service		
Your current care approvals		
Home support SaH End-of-Life Pathway - Short-term – Care management		
Service:	Approved from:	Approved to:
Home support care management	DD/MM/YYYY	DD/MM/YYYY
Emergency approval:	No care reason:	

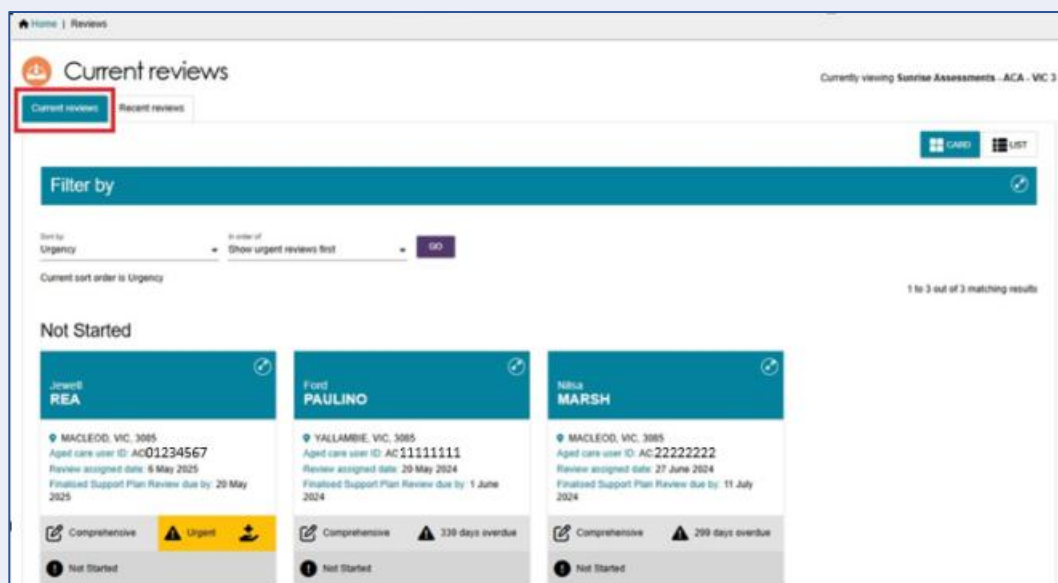
Support Plan Reviews

Viewing a Support Plan Review

1. Select the **Reviews** tile on the home page to view all Support Plan Reviews assigned to you.



2. Open the **Current reviews** tab to view your assigned Support Plan Reviews.



3. Select the **expand** button at the top of a review card to view more details.

The review card displays:

- the assessment type
- the review urgency
- whether the review is overdue.

If the review relates to the **End-of-Life Pathway**, the card also displays the End-of-Life Pathway icon.

Not Started

First Name LAST NAME SUBURB, STATE, 1111 Aged care user ID: ACXXXXXXXXX1 Review assigned date: DD Month Year Finalised Support Plan Review due by: DD Month Comprehensive  Urgent  Not Started	First Name LAST NAME SUBURB, STATE, 1111 Aged care user ID: ACXXXXXXXXX1 Review assigned date: DD Month Year Finalised Support Plan Review due by: DD Month Comprehensive  339 days overdue Not Started	First Name LAST NAME SUBURB, STATE, 1111 Aged care user ID: ACXXXXXXXXX1 Review assigned date: DD Month Year Finalised Support Plan Review due by: DD Month Comprehensive  299 days overdue Not Started
---	---	---

- If the review is for **End-of-Life Pathway** services, select the **Edit** (pencil) icon to verify or add the **End-of-Life Pathway Form**. For information about verifying the End-of-Life Pathway Form, refer to the [My Aged Care Assessment Manual](#).

First Name LAST NAME

Female, 90 years old, 4 August 1935

Requested by
Client

Contact:
First Name Last Name
02 62626262

Request submitted by: First Name Last Name
Client last assessed by: First Name Last Name

Request dates
Date requested: 6 May 2025

Finalised Support Plan Review due by 20 May 2025

End-of-Life form verification: Verification not started 

Reason for request
Why is this request urgent?
EOL Pathway

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

Impact on client's change needs:
EOL pathway required

VIEW FULL CLIENT RECORD VIEW ALL CLIENT NOTES  VIEW CLIENT REPORT

START SUPPORT PLAN REVIEW TRANSFER SUPPORT PLAN REVIEW

Starting a Support Plan Review

Follow these steps to start a Support Plan Review assigned to you.

- Expand the client card in either **Card View** or **List View**, then select **START SUPPORT PLAN REVIEW**.

Alternatively, go to the **Current reviews** page, expand the client card, and select **START SUPPORT PLAN REVIEW**.

Expanded client card or list view

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

Assessor Portal Logout

Home | Find a client |

First Name LAST NAME

Male, 93 years old, 10 January 1930, ACXXXXXXXX1
1 Test Street, Example Suburb, STATE, XXXX

Primary contact: First Name Last Name 6162626262
No support relationships recorded

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

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

Tasks and Notifications

Client tracker

Client summary

Assessments

Home Support Assessment Screening

Finalised on 9 February 2023
Community Aged Care
02 0404 0404

Complete on 12 June 2020

Expanded client card or list view, with the client tracker expanded showing that the client has reached the Support Plan Review stage.

First Name LAST NAME

Female, 77 years old, 5 July 1949, ACXXXXXXXX1
1 Test Street, Example Suburb, STATE, XXXX

Primary contact: First Name Last Name – 0404 040 040
[View support network](#)

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

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

Client tracker

Registered Assessment Waiting for services Receiving services Support plan review

A support plan review is in progress to review care needs.
Next step - An assessment organisation may be in touch to discuss the support plan review.
If you have any questions about the support plan review, you can call the assessment organisation using the phone number in the summary table below.

Your services have started.
Next step - Call the provider for more information about services or to advise of any change in care needs. The phone number is in the summary table below.

Your referral for services has been sent to one or more providers.
Next step - A provider will be in touch to discuss services.

An assessment has been completed and services have been recommended.
Next step - If recommended services are approved, an assessor will be in touch to help find a service provider. If you haven't heard anything, you can call the assessment organisation using the phone number in the summary table below.
Alternatively, use the Find a Provider tool on the My Aged Care website at www.myagedcare.gov.au/find-a-provider.

Client summary

Current Reviews Page

The screenshot shows the 'Current reviews' page with a modal window open. The modal title is 'First Name LAST NAME'. It contains the following information:

- Client details:** Female, 77 years old, 5 November 1948.
- Requested by:** Assessor Sunrise Assessments - ACA - VIC 3.
- Contact:** UAT Ford UAT Lovell, 02 0404 040 040, marquise.asncraft@tesua.law.
- Request submitted by:** UAT Ford UAT Lovell.
- Client last assessed by:** UAT Ford UAT Lovell.
- Request dates:** Date requested: 1 May 2025, Date started: 1 May 2025.
- Finalised Support Plan Review due by:** 16 May 2025.

At the bottom of the modal, there are three buttons: 'VIEW FULL CLIENT RECORD', 'VIEW ALL CLIENT NOTES', and 'VIEW CLIENT REPORT'. Below these, there are two buttons: 'CONTINUE TO SUPPORT PLAN REVIEW' (highlighted with a red box) and 'FLAG AS END OF LIFE'.

2. In the **Before you start the Support Plan Review** window, select one of the following options:

- **CONTINUE TO SUPPORT PLAN REVIEW**
- **RECOMMEND A NEW ASSESSMENT**

Select **CONTINUE TO SUPPORT PLAN REVIEW** to start the review.

If the client's circumstances have changed significantly and you have evidence that they require a higher level of care, such as a letter from a GP or allied health professional, select [RECOMMEND A NEW ASSESSMENT](#) instead of completing a Support Plan Review.

! You do not need to complete a Support Plan Review to extend an End-of-Life episode from 12 weeks to 16 weeks. The system extends the episode automatically. Completing a Support Plan Review during an active End-of-Life episode immediately ends End-of-Life funding.

The screenshot shows the 'Before you start the Support Plan Review' window. It contains the following text:

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

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

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

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

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

At the bottom, there are three buttons: 'CONTINUE TO SUPPORT PLAN REVIEW' (highlighted with a red box), 'RECOMMEND A NEW ASSESSMENT', and 'CANCEL'.

3. When prompted, record the client's consent to share their information with **My Health Record**.
- Select **Yes** or **No** based on the client's response.
 - Select who made the decision from the drop-down list.
 - If a supporter guardian provides consent, enter their first name before continuing.

Consent to share information with My Health Record

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

Information

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

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

☐ No ☐ Yes

Consent decision by *

Decision made by

Decision made by

Client

Supporter Guardian

0 / 255

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

4. If the client does not consent to sharing their support plan with **My Health Record**, enter a reason for the decision.

If someone other than the supporter guardian made the decision, enter the person's first name and the reason for declining consent.

Consent to share information with My Health Record

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

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

☒ No ☐ Yes

Consent decision by *

Client

Consent denial reason *

Please select a reason for not providing the consent

Please select a reason for not providing the consent

Do not wish to disclose

Other

Privacy concerns

CONTINUE TO SUPPORT PLAN REVIEW CANCEL

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

Consent to share information with My Health Record

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

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

☐ No
 ☒ Yes

Consent decision by *

Supporter Guardian

Supporter Details

First name: *
Roger

Last name:
Yeast

Comments:

0 / 255

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

6. After you start the review, you can update information in the following sections:

- Assessment Summary
- Client Motivations
- Goals & Recommendations, including linking support and reablement recommendations
- Manage Services & Referrals
- Associated People
- Review

When you finish updating the support plan, select **COMPLETE & FINALISE SUPPORT PLAN REVIEW**.

Support plan and services

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

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

IAT Outcome and Classifications

Client concerns and goals

ADD AREA OF CONCERN

Concern:
 Concern text

ADD A GOAL

Other recommendations

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

Recommend that the client receive
Domestic assistance 30 November 2024

Recommend that the client receive
Transport 30 November 2024

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

! Previously recommended CHSP, MPS or NATSIFAC services

For clients with **CHSP, MPSP or NATSIFAC** services that were recommended before **23 February 2026**, you cannot delete these services from the client's IAT assessment during a Support Plan Review or while the support plan is **Undergoing Support**.

In the **Goals & Recommendations** section of the client's support plan, historical **CHSP, MPSP and NATSIFAC** services do not display a **Delete** button.

The screenshot shows the 'Assessor Portal' interface. At the top is a navigation bar with links like 'My Dashboard', 'Find a client', 'Assessments', 'Reviews', etc. Below this is a client header section with the name 'First Name LAST NAME' and contact information. The main content area is titled 'Client concerns and goals' and 'Other recommendations'. Under 'Other recommendations', there are two rows of recommendations. The first row, 'Domestic assistance', is dated '16 May 2019' and is highlighted with a red box. The second row, 'Linking Support', is also dated '16 May 2019' and is highlighted with a red box. To the right of these, there are two more recommendations: 'Meals' dated '20 August 2025' and 'Reablement'. The 'Domestic assistance' and 'Linking Support' recommendations do not have a delete button, while the 'Meals' and 'Reablement' recommendations do. At the bottom, there is a section for 'Recommend for Comprehensive Assessment' with a button 'RECOMMEND FOR COMPREHENSIVE ASSESSMENT' and a button 'SUPPORT PERIOD COMPLETE - FINALISE SUPPORT PLAN'.

7. The **Complete & Finalise Support Plan Review** page opens.

- Complete all mandatory fields, including the **Outcome of support plan review** and details of who participated in the review.
- You can also record service outcomes and comments for each service recommendation.
- Select **COMPLETE & FINALISE SUPPORT PLAN REVIEW**.

Complete & finalise support plan review for First Name LAST NAME

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

Reason for this support plan review started on 11 June 2026
Change in care needs

Outcome of support plan review *
Please provide an outcome of support plan review.

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

0 / 1000

Support plan conducted with *
Please select conducted with.

Service Recommendations

Domestic assistance

Outcome
Referral Code Generated

Comments

0 / 500

COMPLETE & FINALISE SUPPORT PLAN REVIEW CANCEL

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Please provide an outcome of support plan review.
Please select conducted with.

Australian Government
Department of Health and Aged Care
myagedcare

8. If the [review outcome is a reassessment](#), enter the review outcome, the reason for the new assessment referral, and the organisation that will receive the referral.
- You can only create a new assessment referral when the client requires one or more of the following:
 - Transition Care
 - Residential Care
 - Residential Respite
 - Services because the client has relocated
 - End-of-Life Pathway (for clients who do not already receive ongoing Support at Home services)
 - Services after an End-of-Life Pathway episode (for clients who do not already receive ongoing Support at Home services)
 - Assistive Technology or Home Modifications that are not already in place
 - A new or different Support at Home classification
 - CHSP classification
 - Restorative Care Pathway
 - Services after a Restorative Care Pathway.

! A new assessment after the End-of-Life Pathway is only required if the person did not receive an inactive Support at Home classification during their initial assessment.

If the person has an inactive Support at Home classification, continue with the Support Plan Review unless changes in their needs or circumstances require a reassessment.

f

Recommending a new assessment

Follow these steps if the client's circumstances have changed and it is more appropriate to refer them for a new assessment instead of completing a Support Plan Review.

1. Expand the client card in either **Card View** or **List View**, then select **START SUPPORT PLAN REVIEW**.

Alternatively, go to the **Current reviews** page, expand the client card, and select **START SUPPORT PLAN REVIEW**.

Expanded client card view or list view

Assessor Portal Logout

Home | Find a client |

First Name LAST NAME
Male, 93 years old, 10 January 1930, AC-XXXXXXX1
1 Test Street, Example Suburb, STATE, XXXX

Primary contact: First Name Last Name 61 0404 040 0404
No support relationships recorded

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

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

Tasks and Notifications

Client tracker

Client summary

Assessments

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

Current Reviews page

Current reviews

Currently viewing Sunrise Assessments - ACA - VIC 3

Filter by

Sort by: Urgency | Show urgent reviews

Current sort order is Urgency

In Progress

Item: NEWKIRK

MACLEOD, VIC, 3085
Aged care user ID: AC60870008
Review assigned date: 27 June 2024
Finalised Support Plan Review due by: 12 July 2024

Comprehensive | Urgent - 304 days overdue | In Progress

First Name LAST NAME

Female, 77 years old, 5 November 1948

Requested by
Assessor
Sunrise Assessments - ACA - VIC 3

Contact
First Name Last Name
02 6161 6161
example@test.com.au

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

Request submitted by: First Name Last Name
Client last assessed by: First Name Last Name

Request dates
Date requested: 1 May 2025
Date started: 1 May 2025
Finalised Support Plan Review due by 16 May 2025

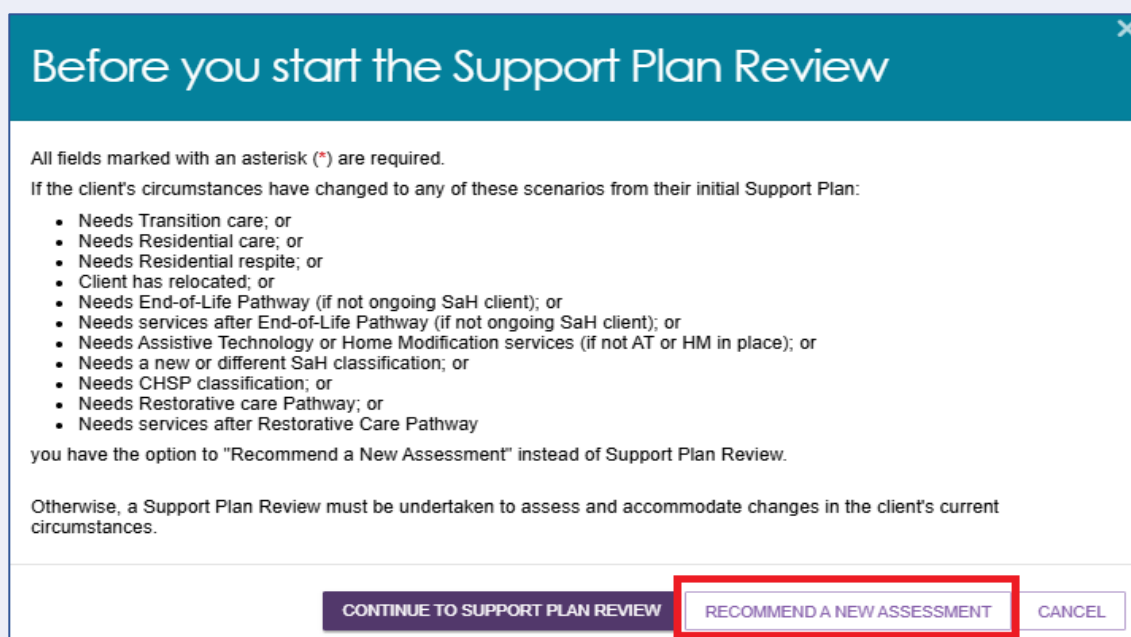
VIEW FULL CLIENT RECORD | VIEW ALL CLIENT NOTES | VIEW CLIENT REPORT

CONTINUE SUPPORT PLAN REVIEW | FLAG AS END OF LIFE

1 to 6 out of 6 matching results

Some assessments have overdue SLAs and need to be scheduled

2. In the **Before you start the Support Plan Review** window, select **RECOMMEND A NEW ASSESSMENT**.



Before you start the Support Plan Review

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

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

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

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

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

CONTINUE TO SUPPORT PLAN REVIEW **RECOMMEND A NEW ASSESSMENT** **CANCEL**

3. A window opens for you to complete or finalise the Support Plan Review and create a referral for a new assessment.
- a) Select the reason for the new assessment. Available options include:
- Needs Transition Care
 - Needs Residential Care
 - Needs Residential Respite
 - Client has relocated
 - Needs End-of-Life Pathway (for clients who do not receive Support at Home services)
 - Needs services after the End-of-Life Pathway (for clients who do not receive Support at Home services, such as CHSP clients)
 - Needs Assistive Technology or Home Modifications that are not already in place
 - Needs a new or different Support at Home classification
 - Needs a Commonwealth Home Support Programme classification
 - Needs a Restorative Care Pathway
 - Needs services after a Restorative Care Pathway.

Complete/finalise Support Plan Review & First Name LAST NAME for assessment



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

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

What is the reason for the new assessment? *

Select one

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

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

Assign this referral to: *

- ☒ Myself / My organisation
☐ Another Organisation

Please select the assessment type: *

Comprehensive Assessment

Please select outlet for this referral *

ABC Outlet

Assessment setting: * ?

- ☐ Hospital
☒ Non-Hospital

Priority * ?

Medium

Comments:

Comment text here

COMPLETE/FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT

CANCEL



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

You can refer a client for a new assessment when you complete a Support Plan Review.

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

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

Complete & finalise support plan review for First Name Last Name

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

☐ Remote Assessment ?

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

Outcome of support plan review *

A new assessment required

Not selected

No changes to support plan

Updates to the existing plan

A new assessment required

SPR cancelled

Other

2. Complete all mandatory fields on the **Complete & Finalise Support Plan Review** page.
3. At the bottom of the page, create an assessment referral before you complete the review.

You can assign the referral to:

- **Myself**
- **My Organisation**
- **Another Organisation.**

Assign this referral to:*

☐ Myself / My organisation

☐ Another Organisation

COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT

NO, CANCEL

If you select Myself or My Organisation:

- Select the assessment type.
- Select the referral outlet.
- If you selected a **Comprehensive Assessment**, select the assessment setting.
- Select the referral priority.
- Add comments if required.
- Select **COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT**.

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

Assign this referral to:*

☒ Myself / My organisation

☐ Another Organisation

Please select the assessment type: *

Comprehensive Assessment

Please select outlet for this referral *

Example Outlet

Assessment setting: ?

☐ Hospital

☒ Non-Hospital

Priority ?

Medium

Comments:

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

If you select Another Organisation:

- Select the assessment type.
- If you selected a **Comprehensive Assessment**, select the assessment setting.
- Search for the assessment organisation using either the client's address or an alternative assessment address.

If you select **Use the client's address**, the system removes any alternative assessment addresses from the client's profile when it issues the referral.

Assign this referral to:*

☐ Myself / My organisation

☒ Another Organisation

Please select the assessment type: *

Comprehensive Assessment

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

Assessment setting: ?

☐ Hospital

☒ Non-Hospital

Search for Assessment Organisation: *

☒ Use the client's address

Client address

Unit 32 Lot Number 192 5 OXLEY Avenue MARGATE QLD 4019

☐ Enter an alternative assessment address

Unit 32 Lot Number 192 5 OXLEY Avenue MARGATE QLD 4019

SEARCH

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

If you enter an alternative assessment address, you can use the displayed address or select the **Edit** (pencil) icon to enter a different address.

Search for Assessment Organisation: *

☐ Use the client's address

Client address

Unit 32 Lot Number 192 5 OXLEY Avenue MARGATE QLD 4019

☒ Enter an alternative assessment address

Lot Number 193 OXLEY AVENUE, MARGATE, QLD, 4019  

- Select **SEARCH** and choose the appropriate assessment organisation.
- Select the assessment priority.
- Add comments if required.

4. Select **COMPLETE & FINALISE SUPPORT PLAN REVIEW & REFER ASSESSMENT**.

SEARCH

Select Assessment Organisation*

☐ Assessment 123 - ACA - Canberra ACT, PH 02 6161 6161

☒ Aged Care Assessor 321 - ACA - Canberra ACT Ph 02 6262 6262

Priority * 

Medium

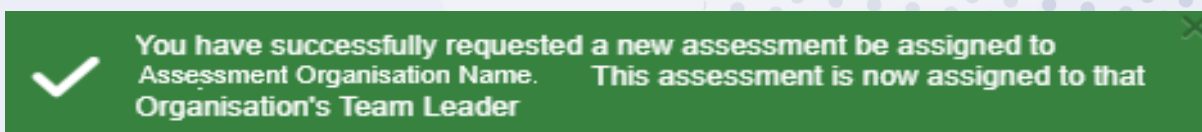
Comments:

Comments description

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

5. When you complete the Support Plan Review, a green confirmation banner appears.

- If you assigned the referral to yourself, the new assessment appears in the **Current assessments** tab.
- If you assigned the referral to **My Organisation** or **Another Organisation**, it appears in the **Incoming referrals** queue for a team leader.



! All assessments, including those created from a **Support Plan Review**, must go through the triage process.

For more information refer to [My Aged Care – Assessor Portal User Guide 3 – Managing referrals for assessment and support plan reviews](#).

Ad hoc Support Plan Reviews

You can start an ad hoc **Support Plan Review** for any client assessed by your assessment outlet. You do not need an assigned Support Plan Review.

To start an ad hoc review, select **START SUPPORT PLAN REVIEW** from any tab in the client's record. You can also start a review by selecting the client card on the **Current Reviews** page.

An ad hoc review overrides any scheduled review. If the scheduled review is no longer required, the team leader should cancel it from the **Upcoming Reviews** tab.

Scheduling an Ad hoc Support Plan Review

Schedule an ad hoc **Support Plan Review** when a significant change in the client's needs, health, or circumstances affects the level or type of care they require.

1. Go to the **Review** tab on the **Support Plan and Services** screen.

The screenshot shows the 'Support plan and services' interface. At the top, there is a teal header with client information: 'First Name LAST NAME', 'Female, 87 years old, 15 April 1938, AC XXXXXXXX1', '1 Test Street, Example Suburb, STATE, XXXX', and 'refers to speak Croatian'. Below the header is a navigation bar with tabs: 'Identified needs', 'Goals & recommendations', 'Decisions', 'Manage services & referrals', 'Associated People', and 'Review'. The 'Review' tab is highlighted with a red box. Below the tabs, there is a section titled 'Schedule a review' with the subtitle 'Schedule a date to review the client's Support plan.' It includes a 'Review Date: *' field with a calendar icon, a 'SAVE CHANGES' button, and two large buttons at the bottom: 'COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER' and 'RETURN TO CLIENT'.

2. Under **Schedule a Review**, select the **Calendar** icon, choose a future review date, and select **SAVE CHANGES**.

First Name LAST NAME
 male, 87 years old, 15 April 1938, AC:XXXXXXXX1
 1 Test Street, Example Suburb, STATE, XXXX
 refers to speak Croatian

Support plan and services

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

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

Schedule a review

Schedule a date to review the client's Support plan.

Review Date: * 

(e.g. dd/mm/yyyy)

SAVE CHANGES

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER RETURN TO CLIENT

3. Select **COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER**.

Support plan and services

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

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

Schedule a review

Schedule a date to review the client's Support plan.

Review Date: * 

(e.g. dd/mm/yyyy)

SAVE CHANGES

COMPLETE SUPPORT PLAN AND CONTINUE TO MATCH AND REFER RETURN TO CLIENT

4. On the client's **Plans** tab, select **START SUPPORT PLAN REVIEW**.

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

Approvals **Plans** Attachments Services My Aged Care interactions Notes Tasks and Notifications

Assessment history 

 Comprehensive Assessment 9 May 2025

5. On the next screen, select **CONTINUE TO SUPPORT PLAN REVIEW**.

Before you start the Support Plan Review

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

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

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

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

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

CONTINUE TO SUPPORT PLAN REVIEW

RECOMMEND A NEW ASSESSMENT

CANCEL

6. Complete the required fields on the **Consent** screen and select **CONTINUE TO SUPPORT PLAN REVIEW**.

Consent to share information with My Health Record

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

Information

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

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

☐ No ☒ Yes

Consent decision by *

Client

Comments:

CONTINUE TO SUPPORT PLAN REVIEW

CANCEL

7. When prompted, select the reason for the client's change in circumstances.

Start support plan review for First Name LAST NAME

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

What circumstances have changed for the client? *

Please select...

- Hospital Discharge
- Fall(s) or risk of falling
- Change in medical condition
- Change in cognitive status
- Change in care needs
- Increasing frailty
- Change in caring arrangements
- Change in living arrangements
- Review service recommendations
- Vulnerable client
- Needs Transition Care
- Needs Residential Care
- Needs Residential Respite
- Client has relocated
- Needs End-of-Life Pathway
- Review End-of-Life Pathway
- Review HM tier
- Review AT tier
- Needs Restorative Care

0 / 1000

.jpeg, .jpg, .bmp, .png, .docx, .xlsx, .pdf, .txt

START SUPPORT PLAN REVIEW CANCEL

- Enter the required information and upload supporting documents, such as a letter from a qualified health professional, if needed.
- Select **START SUPPORT PLAN REVIEW**.

Start support plan review for First Name LAST NAME

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

What circumstances have changed for the client? *

Change in care needs

How has this affected the client's need? *?

Client's day to day routine is impacted due to declining health condition

73 / 1000

Add additional information to support your request? ?

UPLOAD ADDITIONAL INFORMATION1

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

START SUPPORT PLAN REVIEW CANCEL

Transferring a Support Plan Review

Assessors and team leaders can transfer a **Support Plan Review** to another assessment organisation.

1. Go to **Current Reviews** and select the client card for the Support Plan Review you want to transfer. Select **TRANSFER SUPPORT PLAN REVIEW**.

The screenshot shows the 'Current reviews' interface. On the left, there's a 'Filter by' section with 'Urgency' selected. Below it, a 'Not Started' section shows a client card for Melina Ramsey, aged care user ID AC32745497, with a review assigned date of 7 June 2024. On the right, a modal titled 'First Name LAST NAME' is open, displaying client details: Female, 64 years old, 30 July 1940. It lists the request as 'Health Professional Admin' by 'Grayden Jeanbaptiste'. The reason for request is 'Client's change in circumstances: Hospital Discharge'. The impact on client's change needs is 'Harley is requesting Domestic Assistance, Meals, Personal Care & Transport for Milena, because increasing functional decline, back pain and falls at home.' At the bottom of the modal, there are buttons: 'VIEW FULL CLIENT RECORD', 'VIEW ALL CLIENT NOTES', 'VIEW CLIENT REPORT', 'START SUPPORT PLAN REVIEW', and 'TRANSFER SUPPORT PLAN REVIEW' (highlighted with a red box).

2. Enter the reason for the transfer.

Search for and select the assessment organisation that will receive the Support Plan Review.

Select **TRANSFER** to complete the transfer.

After the transfer is complete, the system displays a banner reminding you to:

- contact the receiving assessment organisation, and
- obtain the client's consent before transferring the Support Plan Review.

The screenshot shows the 'Transfer this support plan review for First Name Last Name' form. It includes a dropdown for 'What is the reason for transfer?' and a text area for 'Comments:'. Below this is a search section for 'Assessment Organisation' with a radio button to 'Use the client's address' and a list of results including '1000 NICOLE Crescent WODONGA VIC 3690'. There are 'SEARCH', 'TRANSFER' (highlighted with a red box), and 'CANCEL' buttons. At the bottom, there's a banner with a warning icon and text: 'Before making the transfer, please contact the Assessment Organisation you want to refer the client to and provide as much information as possible in the comments box to assist the receiving organisation. Please note, a review can only be transferred once. Please ensure that you have client consent before transferring.' The footer includes 'Accessibility Privacy Disclaimer Terms', 'Copyright © Commonwealth of Australia', 'Australian Government Department of Health', and 'myagedcare'.

! Support Plan Reviews can only be transferred once.

Support Plan Review for Support at Home

Conduct a **Support Plan Review** when a client's circumstances, goals, or care needs change and you need to review their current **Support at Home** services. The review helps ensure the client's services remain appropriate, effective, and aligned with their preferences and needs.

Use the **Goals & Recommendations** tab to record the client's:

- areas of concern
- goals to address those concerns
- service recommendations
- general recommendations
- care type recommendations.

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

Support at Home care types are delivered under the *Aged Care Act 2024*. If a care type recommendation requires delegate approval, [add a care type for delegate decision](#).

Support Plan Review for services following an End-of-Life Pathway episode

You may receive a **Support Plan Review (SPR)** request for a client who is approaching the end of their **End-of-Life Pathway** episode or whose End-of-Life episode has ended and who requires ongoing services.

Complete the Support Plan Review to assess the client's current needs and determine whether to:

- return the client to their previous (latent) **Support at Home** classification, or
- recommend a reassessment so the client can access a higher ongoing **Support at Home** classification.

For example, a client may have originally received a **Support at Home Classification 4**, then accessed the **End-of-Life Pathway**, and now require an ongoing **Support at Home Classification 8** to meet their increased care needs.

In most cases, the client's service provider initiates this Support Plan Review. The provider submits the request by selecting **Review End-of-Life Pathway** as the reason for the Support Plan Review.

Revert to the previous 'latent' SaH classification

Follow these steps to return a client to their previous (latent) **Support at Home** classification.

1. Open the **Support Plan Review (SPR)** request from the client's record.

First Name
LAST NAME

SUBURB, STATE, XXXX

Aged care user ID: ACXXXXXXXX1

Requested review date: DD Month YYYY

Request action date: DD Month YYYY

Not Started

Urgent

2. Review the reason for the request. The service provider may have identified that the client:

- has exceeded their **End-of-Life Pathway** period, or
- is approaching the end of their 16-week End-of-Life services.

First Name LAST NAME

Aged 92 (14 October 1933), Male

Urgent request

Requested: 28 May 2026

Requested action date: 7 June 2026

Files were attached to this request [View client attachments](#)

Requested by

Aged Care Service Provider

Adss In-home Support

Contact

Rogelio Barker

0456 898 790

Deneen.Hite@test.qylbs.fbf

Request submitted by:

Rogelio Barker

Client last assessed by:

Gerson Noland

Reason for request

Why is this request urgent?

test

Clients change in circumstances:

Review End-of-Life Pathway

Impact on client's needs:

gdnadbasj

Primary reason for request:

Request for additional CHSP services for clients who are in receipt of a Support at Home

Services client is currently receiving:

3. Go to the **Goals & Recommendations** tab on the **Support Plan and Services** page.

In the **IAT Outcome and Classifications** section, an information banner shows that the client is currently on the **End-of-Life Pathway** and can only be recommended for a latent or higher ongoing **Support at Home** classification.

Select **Revert to Ongoing Support at Home Classification** or **Override to Transitioned HCP Classification**.

Client currently on EOL can only be recommended Latent or Higher Ongoing SAH classification.

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

100

OFFICIAL

Revert to Ongoing SAH Classification example

Support plan and services PRINT COPY OF SUPPORT PLAN

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment Existing classification: SaH Classification 4

IAT Outcome: SaH Classification 4

Recommended classification: SaH End-of-Life Pathway
AT Medium

Override reason: Higher level service needs

Override reason description: EOL test

REVERT TO ONGOING SAH CLASSIFICATION

Override to Transitioned HCP Classification example

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

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

Existing classification: Transitioned HCP Level 2 (Pending allocation)
SaH End-of-Life Pathway
AT Medium

Client currently on EOL can only be recommended Latent or Higher Ongoing SAH classification.

OVERRIDE TO TRANSITIONED HCP CLASSIFICATION

4. When the confirmation window appears, select **REVERT** or **OVERRIDE** to continue.

Revert to ongoing SAH Classification pop up example

Revert to ongoing SaH Classification

Revert to ongoing SaH Classification for PGrihana SONDONTUSEGP:

Classification: SaH Classification 4

Classification type: Ongoing

REVERT CANCEL

Override to Transitioned HCP Classification pop up example

Override to Transitioned HCP Classification

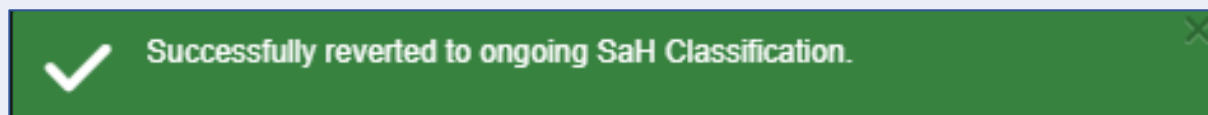
Override current SaH Classification for Hong BLOCK to ongoing Transitioned Classification:

Classification: Transitioned HCP Level 2

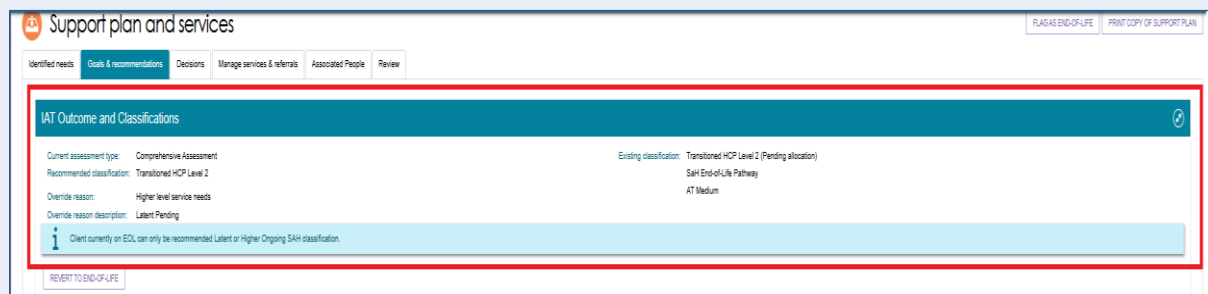
Classification type: Ongoing

OVERRIDE CANCEL

5. If the update is successful, the system displays a green confirmation banner.

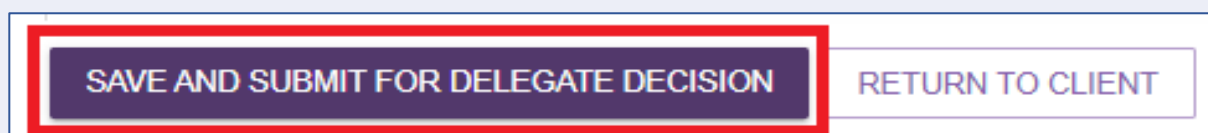


6. The **IAT Outcome and Classifications** section updates to show the client's current classification and the override reason **Latent Pending**.

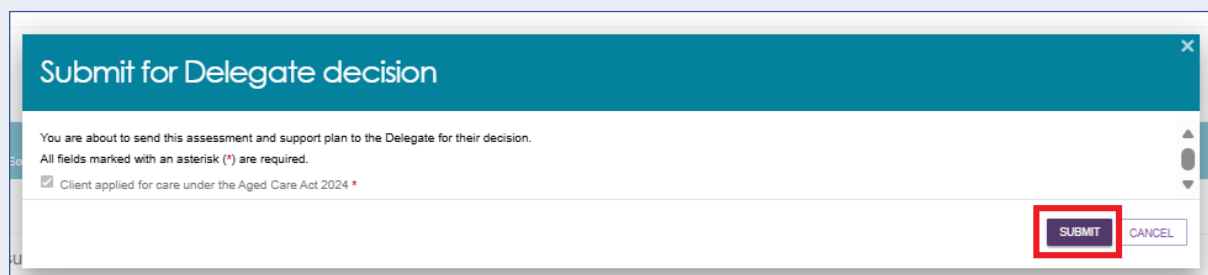


7. Complete the Support Plan Review and record the outcome in the system. This transitions the client from the **End-of-Life Pathway** to their latent ongoing **Support at Home** classification and supports continuity of services.

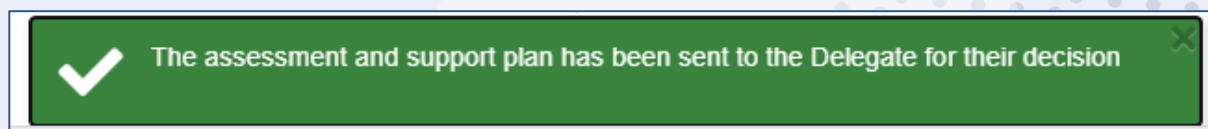
Go to the **Decisions** tab, then select **SAVE AND SUBMIT FOR DELEGATE DECISION**.



8. In the **Submit for Delegate Decision** window, confirm that the client applied for care under the **Aged Care Act 2024** by selecting the checkbox, then select **SUBMIT**.



9. The system displays a green confirmation banner to show that it has sent the assessment and support plan to the delegate for a decision.



Reassessment for a New Support at Home Classification Following an End-of-Life Episode

1. Go to the client's **Plans** tab and select **REQUEST A REVIEW**.

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

Welcome Shonda from ACH Group Health & Wellbeing

Service referrals Find a client Review requests Tasks and notifications Retrieve a referral code My Aged Care interactions Reports and documents SBS Notice Government Provider Management System Logout

Home | Find a client | UATAUTOLaylaw UATAUTOHillu (UATAUTOBobbiev)

Mr UATAUTOLaylaw UATAUTOAlexandre UATAUTOHillu (UATAUTOBobbiev)
Male, 86 years old, 25 February 1940, ACU/805431
15 LINDSAY WAY GREENWAY ACT, 2900
Primary contact: UATAUTOLaylaw UATAUTOHillu (self) - 0464 619 913
No support relationships recorded

UATAUTOLaylaw UATAUTOHillu support plan

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

Assessment Details

- Assessment information
- Assessment summary
- Needs identified at assessment
- Assessment history

Plan Details

- Current care approvals

REQUEST A REVIEW VIEW CLIENT REPORT

2. On the **Request a Review** page, complete all mandatory fields and upload any relevant documents, such as a care plan.

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

Welcome Shonda from ACH Group Health & Wellbeing

Service referrals Find a client **Review requests** Tasks and notifications Retrieve a referral code My Aged Care interactions Reports and documents SBS Notice Government Provider Management System Logout

Home | Client Record | Request a review

Mr UATAUTOMaryami UATAUTOHobartx UATAUTOFAYH (UATAUTOJaycel)
Male, 78 years old, 9 December 1947, AC4620649 (Lot Number 28 SEENEY STREET ZILLMESE, QLD, 4034)

Request a Review

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

Request details

What circumstances have changed for the client? *

How has this affected the client's needs? *

Does this request need to be actioned urgently? ☒ Yes ☐ No

What type of subsidised aged care is the client receiving? *

- ☐ Support at Home (SafI)
- ☐ Commonwealth Home Support Programme (CHSP)
- ☐ Support at Home and Commonwealth Home Support Programme
- ☐ Flexible Care
- ☐ Residential Care

Primary reason for Support Plan Review Request *

- ☐ Request for additional CHSP services for clients who are in receipt of a Support at Home
- ☐ Request for additional CHSP services or changes to CHSP services for clients who are only receiving CHSP services currently
- ☐ There is a change in a client's circumstances and they have an immediate need for access to Support at Home services
- ☐ There is a significant change in the client's needs and additional Aged Care Act 2024 (the Act) based aged care services are required

Please provide a copy of the client's care plan and individualised budget. *

ADD CARE PLAN ADD BUDGET

Is there any sensitive client information within the attached care plan or individualised budget? *

☐ Yes ☒ No

The team leader will assign the assessment to an appropriate assessor.

Assign this review for First Name LAST NAME

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

Change support plan review priority?
Urgent

Reason description: *
TEST

Assign to: *

- ☐ First Name LAST NAME (0 assessments and 0 reviews assigned)
- ☐ First Name LAST NAME (0 assessments and 0 reviews assigned)
- ☐ First Name LAST NAME (0 assessments and 0 reviews assigned)
- ☐ First Name LAST NAME (0 assessments and 0 reviews assigned)
- ☐ First Name LAST NAME (0 assessments and 0 reviews assigned)
- ☐ First Name LAST NAME (0 assessments and 0 reviews assigned)
- ☐ First Name LAST NAME (0 assessments and 0 reviews assigned)

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ASSIGN CANCEL

- The assigned assessor should go to the **Reviews** tile on the Assessor Portal home page and open the **Not Started** section on the **Current Reviews** page.

Home | Reviews

Current reviews

Currently viewing: ABC Outlet

Current reviews Recent reviews

Filter by

Sort by: Urgency In order of: Show urgent reviews first GO

Current sort order is Urgency

1 to 7 out of 7 matching results

In Progress

First Name LAST NAME
MARGATE, QLD, 4019
Aged care user ID: AC 999999999
Review assigned date: 27 May 2026
Delegate Decision due by: 29 May 2026
Home Support Urgent - 10 days overdue In Progress

First Name LAST NAME
WOOL BAY, SA, 5575
Aged care user ID: AC 888888888
Review assigned date: 13 April 2026
Delegate Decision due by: 31 May 2026
Comprehensive Urgent - 8 days overdue In Progress

First Name LAST NAME
BRISBANE CITY, QLD, 4000
Aged care user ID: AC 777777777
Review assigned date: 21 April 2026
Delegate Decision due by: 30 May 2026
Comprehensive Urgent - 9 days overdue In Progress

Not Started

First Name LAST NAME
BLACKBURN VIC 3130
Aged care user ID: AC 666666666
Review assigned date: 29 May 2026
Finalised Support Plan Review due by: 18 January 2025
Home Support 506 days overdue Not Started

4. Find the client's review card and select **START SUPPORT PLAN REVIEW**.

First Name LAST NAME

Male, 67 years old, 5 March 1959

Requested by Representative

Contact:

First Name LAST NAME
0404 040 040

Request submitted by: First Name LAST NAME

Request dates

Date requested: 4 January 2025

Finalised Support Plan Review due by 18 January 2025

Reason for request

Client's change in circumstances:
Change in care needs

Impact on client's change needs:
First Name LAST NAME needs Assessment because He is struggling to find a provider who has staff that can speak Arabic. He wants home care package. He had lower back surgery and can't walk distances. He use a walking stick. . The client requires an Aged Care Assessment.

VIEW FULL CLIENT RECORD

VIEW ALL CLIENT NOTES

VIEW CLIENT REPORT

START SUPPORT PLAN REVIEW

FLAG AS END-OF-LIFE

TRANSFER SUPPORT PLAN REVIEW

5. In the **Before you start the Support Plan Review** window, select **RECOMMEND A NEW ASSESSMENT**.

Before you start the Support Plan Review

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

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

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

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

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

CONTINUE TO SUPPORT PLAN REVIEW

RECOMMEND A NEW ASSESSMENT

CANCEL

6. Select **START TRIAGE**. After completing triage, select **START ASSESSMENT**.

Start Triage

First Name LAST NAME

Assessor First Name LAST NAME

Support plan review 2 June 2026

Support plan 14 November 2019

Comprehensive Assessment 2 June 2026

Comprehensive Assessment 18 August 2025

Comprehensive Assessment 27 July 2023

Home Support Assessment 9 January 2023

dogs were spent and the grub was getting lowAnd on I went though the dogs were spent and the grub was getting lowAnd on I went though the dogs were spent and the grub was getting lowAnd on I went though the dogs

04/03/2025

VIEW ALL 10 CLIENT NOTES

Comments TEST

Cohabitant details

VIEW FULL CLIENT RECORD VIEW CLIENT REPORT

START TRIAGE ASSIGN TO TRIAGE DELEGATE REFER URGENT SERVICES

Start Assessment

First Name LAST NAME

Assessor First Name LAST NAME

Triage conducted by First Name LAST NAME

Support plan Triage Completed

Comprehensive Assessment Triage Completed

dogs were spent and the grub was getting lowAnd on I went though the dogs were spent and the grub was getting lowAnd on I went though the dogs were spent and the grub was getting lowAnd on I went though the dogs

04/03/2025

VIEW ALL 10 CLIENT NOTES

Comments TEST

Cohabitant details

VIEW FULL CLIENT RECORD VIEW CLIENT REPORT

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

7. Complete the assessment and select **FINALISE IAT**.

Finalise IAT and go to support plan

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

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

FINALISE IAT TAKE ME BACK TO THE ASSESSMENT

8. The reassessment outcome appears in the **Goals & Recommendations** tab.

An information message explains that you can only recommend the client's latent **Support at Home** classification or a higher ongoing classification.

Support plan and services

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

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment

IAT Outcome: Self Classification 7

Existing classification: Transitioned HCP Level 4 Self End-of-Life Pathway AT Medium

Client currently on EOL can only be recommended Latent or Higher Ongoing SAH classification.

ACCEPT OVERVIEW

9. Accept the new **Support at Home** classification, complete the assessment and support plan, and submit the recommendation for delegate decision using the standard process.

Support plan and services

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

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

IAT Outcome and Classifications

Current assessment type: Comprehensive Assessment
 IAT Outcome: Safe Classification 7
 Existing classification: Transformed HCP Level 4
 Safe End-of-Life Pathway
 AT Medium

i Client currently on EOL, can only be recommended Latent or Higher Ongoing SAH classification.

ACCEPT | OVERRIDE

Client concerns and goals

ADD AREA OF CONCERN

Concern:
 Before I got married I had an Respite about bringing up 946523953

ADD A GOAL

Goal: I would like to get help that assists me to stay at home.

Concern:
 And at night for wonderful glory of the twinkling stars what an awesome + DNF C14045

ADD A GOAL

Goal: I can access respite care when I need it.