1.5.4. Multi-Purpose Service Program (MPSP)

Existing MPSP clients on 1 November 2025

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

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

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

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

Note:

An individual's transitional status is confirmed by a notice given to the client, via their MPSP provider. This notice is also attached to their My Aged Care Client Record. By July 2026, relevant approvals and referrals will also be retrospectively added to Department of Health, Disability and Ageing systems to facilitate these individuals moving between MPSP and mainstream services in future.

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

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

• seek to undergo a re-assessment if they only have a MPSP classification level provided at transition time, or

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

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

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



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

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

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

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

Note:

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

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

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

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

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

Existing NATSIFACP clients

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

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

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

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

Note:

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

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

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

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

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

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

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

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

1.5.7. Commonwealth Home Support Program (CHSP)

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

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

Note:

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

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

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

1.5.8. Short-Term Restorative Care (STRC) Programme

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

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

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

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

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

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1.5.9. Transition Care Program (TCP)

TCP clients receiving transition care on 1 November 2025

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

New TCP clients post 1 November 2025

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

1.5.10. Residential Care

Residential care clients in residential care on 1 November 2025

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

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

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

1.5.11. Younger People

Younger people receiving existing aged care services

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

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

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Younger people with 'In-flight assessments'

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

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

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

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

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

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

1.6. Aged Care Service List

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

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

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

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

The Aged Care Service List serves several key functions:

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

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

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1.7. Service groups

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

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

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

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

Note:

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

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1.8. Approvals under the *Aged Care Act 2024*

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

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

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

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

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

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

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

Table 5: Service group: Home support

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

Table 6: Service group: Assistive technology

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

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

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Table 7: Service group: Home modifications

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

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

Table 8: Service group: Residential care

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

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

1.9. Deciding if the older person requires aged care services

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

This decision is made based on:

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

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

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

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

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

Important:

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

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1.9.1. Approvals for service types and services

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



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

1.9.2. Approvals for priority categories

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



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

1.9.3. Period of effect of approvals

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

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

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

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



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

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1.10. Accessing funded aged care services

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

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

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

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

1.11. Where approvals can be used

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

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

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

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

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

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

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

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

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Program	Service group – Classification type - Classification level
	Residential care – short-term – Class 0 to 3 Residential care – ongoing – Class 0 to 13

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

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

What you'll find in this chapter

This chapter provides information on the Single Assessment System including:

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

2.1. My Aged Care

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

The key elements of My Aged Care include:

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

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

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

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

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

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

- manage their assessment organisation contact details and set up individual staff members with access to the My Aged Care assessor portal
- manage referrals for assessment
- submit and action requests to create, to register or end supporter relationships and create organisation agent relationships
- complete triage and determine eligibility for an aged care needs assessment
- undertake assessments using the IAT and develop a Support Plan
- make delegate decisions for access to government-funded aged care services
- conduct support plan reviews (SPRs) and reassessments
- refer older people for aged care services
- recommend a period of reablement or for linking support on the Support Plan
- review and update older person records consistent with the assessment and Support Plan outcomes.

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

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

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

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

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

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

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

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2.2. Single Assessment System

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

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

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

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

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

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

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

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

2.3. Aboriginal and Torres Strait Islander assessment organisations

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

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

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

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

These organisations provide older Aboriginal and Torres Strait Islander people:

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

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

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

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

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

Aboriginal and Torres Strait Islander assessment organisations are expected to:

- conduct culturally safe, trauma aware and healing informed assessments using yarning and flexible approaches to build trust with the older Aboriginal and Torres Strait Islander person. Assessments may be delivered at a location that the older person feel most at ease and comfortable
- undertake face-to-face assessments, where possible. This could be in the older person's home, at a community centre, or outdoors at a place of the older person's choosing
- allow for multiple visits, if required, to build trust and develop a relationship
- with client's consent, involve the client's family members, advocates, registered supporter/s or other people who support the client in the assessment process with the client's consent and/or in line with the client's will and preferences
- connect with the older person's GP, service provider and support networks to help inform an assessment, to gain a comprehensive understanding of the client's health and wellbeing, minimising the older person having to tell their story multiple times
- be embedded within the local community. Connecting with the local community with their knowledge of local services, customs and protocols will allow them to support matching appropriate assessors to the older people preferences and needs
- maintain a connection with the older person for the whole journey through to receiving services via assessors and/or Elder Care Support workers. This will help to manage any uncertainty or questions throughout the process
- work with organisations that support stolen generation survivors and their families
- provide interpreting services, when needed, and
- support clients to access services they need (where this cannot be provided by ECS workers or care finders)

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

2.4. Overview of assessment organisation roles and responsibilities

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

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

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

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

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

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

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

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

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

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My Aged Care Assessor Portal - Organisational Administrator User Guide

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

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

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

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

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

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

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

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

2.6. Training requirements for assessment teams

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

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

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

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2.6.1. Training delivery

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

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

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

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

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

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

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

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2.7. The single assessment pathway

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

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

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

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

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

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

2.7.1. Home support assessments

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

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

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

Converting to a comprehensive assessment

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

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

2.7.2. Comprehensive assessments

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

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

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

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

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

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2.8. Other assessment activities

2.8.1. Support plan reviews (SPR)

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

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2.8.2. Wellness and reablement

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

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

2.8.3. Linking support

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

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

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2.8.4. Assessment delegations

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

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



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

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2.8.5. Multi-disciplinary approach

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

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

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

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2.9. Aims and key features of assessment

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

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

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- ensure older people from diverse backgrounds have equitable access to assessment services.
- provide a choice for older Aboriginal and Torres Strait Islander people to access culturally safe, trauma aware and healing informed aged care assessments from Aboriginal and Torres Strait Islander assessment organisations.
- consider both formal and informal services to assist an older person to remain in the setting most appropriate to their needs (such as their own home) to prevent premature or inappropriate admission to residential care.
- build and maintain effective and respectful working relationships with all My Aged Care assessors, service providers and other support agencies.
- provide short-term case management/linking support and short-term care coordination to vulnerable older people to address barriers affecting their access to aged care services, including extending connections with services and organisations in local communities (including those not listed on My Aged Care); and
- use the My Aged Care assessor portal, including the IAT and its built-in validated assessment tools and associated guidance materials to record assessment information accurately, prevent duplication, and re-use (pre-populate) information to deliver assessments of a high quality and standard.

2.10. Assessment quality

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

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

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

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

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

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

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

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

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

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

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2.11. Integrated Assessment Tool (IAT)

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

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

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

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

IAT Offline Form

IAT User Guide

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2.11.1. Validated Assessment Tools

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

Table 12. Validated culturally appropriate assessment tools

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

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

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

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

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

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3. Chapter 3: Referral, registration and screening

What you'll find in this chapter

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

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

3.1. Entry into My Aged Care

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

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

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

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Note:

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

3.1.1. Modes of entry into My Aged Care

Phone

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

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

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

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

Online

Apply for an assessment online

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

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

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

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Web referrals (Make a Referral form)

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

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

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

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

GP e-Referral

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

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

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

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

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

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

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

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



Services Australia website: Aged Care Specialist Officer

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3.1.2. My Aged Care Online Account

Create account and registration

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

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

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3.2. Alternative entry

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Screening

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

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These services are:

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

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

Triage

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

Triage delegates should:

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

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

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

Assessment

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

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

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

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

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3.2.2. Residential care or residential respite care in urgent circumstances

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

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

3.3. Screening

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

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

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

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

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

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

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