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The duties include that registered supporters must:

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

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

**Registered supporter Conflicts of interest**

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

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

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

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

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

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

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

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

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

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

***Suspension and cancellation of a registered supporter***

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

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

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

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***No requirement to register a supporter***

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

***Transitioning to the registered supporter role***

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

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

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

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

### 3.4.2. Organisation Agents

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

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

Getting support to navigate aged care | My Aged Care

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

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## 3.5. Exceptional Circumstances – approving a service without an assessment

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

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

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***Client is receiving services but is refusing an assessment***

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

***If assessment is cancelled or exceptional circumstances do not apply***

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

## 3.6. Emergency Residential Care - Application for Care

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

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

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**Residential care (ongoing or short-term)**

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

In completing the form:

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

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

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

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

### 3.6.1. Intake and assessment process

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

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

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

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# 4. Chapter 4: Referral for assessment

## What you'll find in this chapter

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

The following topics are covered in this chapter:

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

## 4.1. Managing referrals

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

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## 4.2. Referral priority categories

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

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

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

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

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### 4.2.1. Home support assessment priority categories

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

**Table 14. Home support assessment priority categories**

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

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### 4.2.2. Comprehensive assessment priority categories- community setting

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

**Table 15. Comprehensive assessment priority categories – community setting**

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

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## 4.2.3. Hospital assessment priority categories

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

**Table 16. Hospital assessment priority categories**

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

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

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

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

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# 4.3. Actioning referrals

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

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

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

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

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

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

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

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Note:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### 4.3.4. Unlikely to be eligible for an assessment flag

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

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

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

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

### 4.3.5. End-of-Life referrals

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

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**Reviews for the End-of-Life Pathway through the same mechanisms** (team leaders will be able to filter by urgency, but they will be unable to see the visual indicator or filter specifically for End-of-Life). Instead, upon receiving urgent requests for Support Plan Reviews, it is important that team leaders click the double arrow icon to expand the referral card, verify whether it relates to the End-of-Life Pathway and prioritise it accordingly. This must be done for all incoming referrals for Support Plan Reviews to ensure older people seeking access to the End-of-Life Pathway are prioritised. A temporary workaround is available for via Qilk, refer to the Identification of End-of-Life Clients Via Qlik – Guidance on the Assessment Hub for more detailed guidance.

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

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

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

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**Table 17. End-of-Life Form verification options**

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

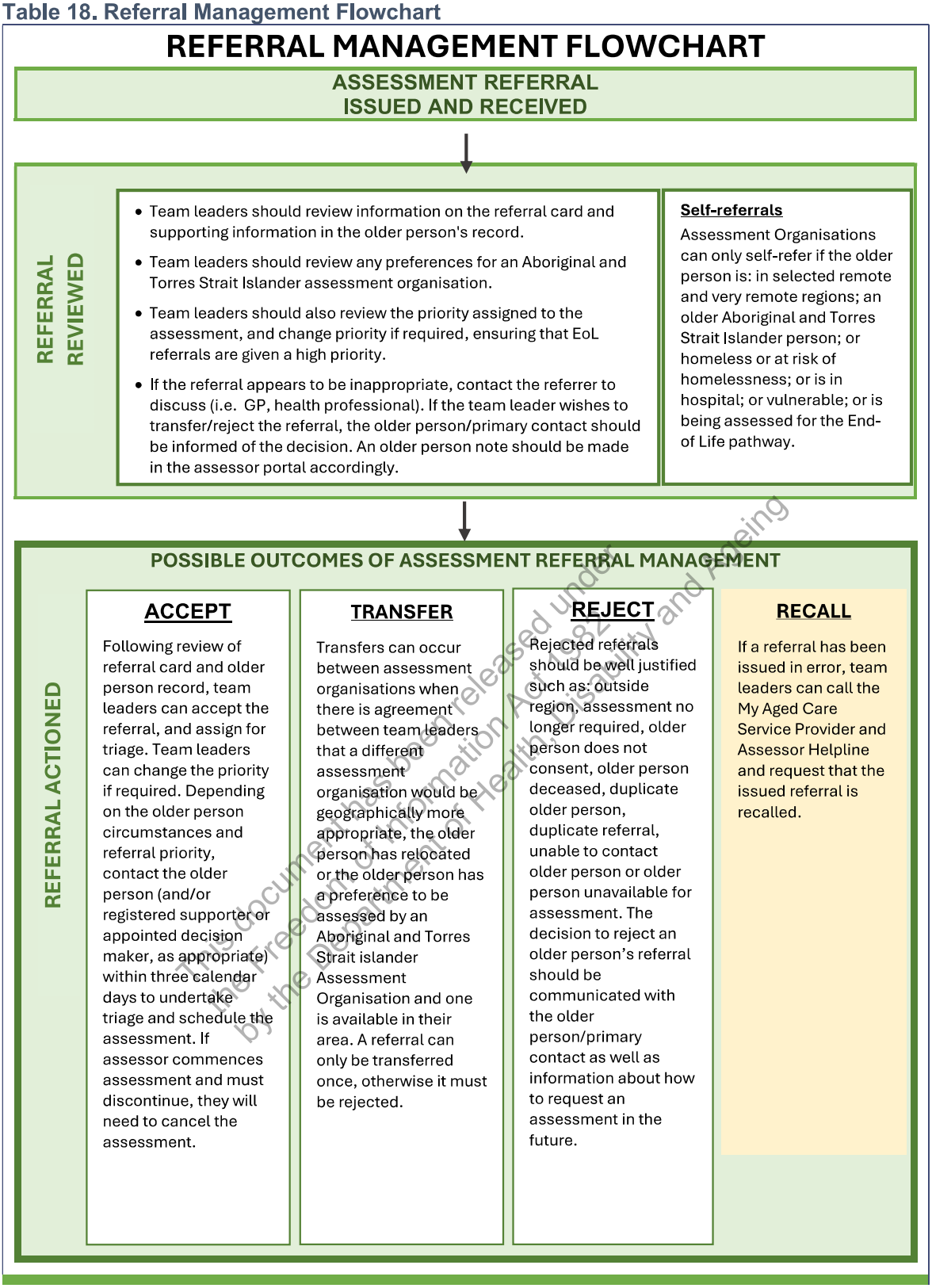
Note: The End-of-Life Pathway can be flagged at any stage of the individual's assessment journey.



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

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Table 18. Referral Management Flowchart




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## 4.3.6. Accept a referral

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

A Team Leader must:

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

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

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## 4.3.7. Transferring referrals

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

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

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

## 4.3.8. Rejecting a referral

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

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

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

**Table 19. Referral rejection - List of values**

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

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

Note:

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

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

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

- These attempts must have been made over the KPI timeframe set for the older person based on the type and priority of the referral (i.e. three phone attempts must be made to contact a high priority home support referral over a 10-day period, a medium priority home support referral must be undertaken over 14 days etc.)
- Any number of other forms of contact e.g. text messages, email, can be used, in conjunction with the minimum of three phone attempts. All contact attempts must be documented.
- For clients who have special needs or maybe high risk, e.g. identified cognitive and/or hearing impairment, no informal supports, it is expected that a **minimum of five attempts** must be made to contact the older person and/or their registered supporter or primary contact. These attempts must include a minimum of 3 phone calls, one text message and one email, all of which are to be undertaken within the KPI timeframe for the type and priority of referral. All contact attempts must be documented.
- After the required number of contact attempts has been made, a letter must be provided advising the older person and their registered supporter advising how to reactivate their assessment referral request, or informing the older person and their registered supporter (and appointed decision maker, if they have one) if they are rejecting, transferring or cancelling their referral (including an explanation of the reason/s). This letter must be uploaded to the client record.
- Where the older person has been admitted to hospital, the referral should only be rejected once the assessor has confirmed that an assessment will take place while the older person is in hospital. AOs need to be cautious before rejecting these referrals as in some cases the older person may still require an assessment once released from hospital (so they do not have to reapply and be put on a wait list again).

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

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

- There is a duplicate older person entry or a duplicate referral.
- There is insufficient information to proceed with the referral.

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

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

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Note:

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

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

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

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

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

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

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

### 4.3.9. Recall a referral

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

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

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

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## 4.4. Self-referrals

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

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

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

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

When creating the self-referral, assessors are encouraged:

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

### 4.4.1. Triage and self-referral

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

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

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

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

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

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

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

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

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

## 4.4.3. Prevention of duplicate records

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

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

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

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

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

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

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## 4.4.4. Verifying the individual's legal name

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

### Legal name vs preferred name

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

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

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Note:

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

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

### Additional information in name field

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

### Special characters

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

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

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

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## 4.5. Support plan reviews and reassessments

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

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

Note: in this manual, the term 'reassessment' is used to describe an assessment that occurs after an older person has already been assessed at least once. From

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1 November, SPRs will be used as a mechanism to adjust an older person's aged care services without needing to undertake a full reassessment. A reassessment will be conducted when there are *significant* changes to a client's needs or circumstances.

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

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

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

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

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

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

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

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

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

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

Where an initial RCP place has been withdrawn due to the person not entering care within the required take up period (56 days, with a possible 28-day extension), a second unit

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must not be approved via an SPR. In these circumstances, an SPR should not be used to attempt to approve a second unit RCP but may be used to assess and approve alternative supports (including the need for a reassessment), based on the person's needs.

### 4.5.1. SPR and reassessment requests

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

A SPR may be requested by:

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

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

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

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

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## 4.5.2. Managing an SPR request

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

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

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

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

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

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### Transfer the request

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

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

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**Recommend a reassessment**

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

**Cancel the request**

Actions if considering cancelling the SPR:

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

Note:

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

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

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

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## 4.6. Deceased older people

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

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

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

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

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

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# 5. Chapter 5: Assessment activities

## What you'll find in this chapter

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

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

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## 5.1. Obtaining consent for triage and assessment

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

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

- Triage Delegates or assessors must use the applicable consent script online via the Assessor Portal (or in the app in the case of self-referrals).
- The Triage Delegate or assessor should read out the consent script/s to ensure the older person understands and is informed of the purpose for collecting the information and how it will be used and stored, and who the personal or sensitive information will be collected from (such as contacting a person's GP, other health professionals, disability service coordinator or service provider, family members or carers). If the older person prefers, the older person can read the consent script/s themselves on a printed form.
- For offline assessments, the assessor must use a hard copy version of the My Aged Care Assessment Consent Form. This form includes the consent scripts and fields to record the consent for assessment and service referrals. It is located via the *Reports and Documents* tile within the My Aged Care assessor portal.

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

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

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

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

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

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

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

- Under the Act, assessors must presume that an older person has the ability to make decisions for themselves. This is known as the presumption of capacity. If an assessor becomes aware of matters that suggest the older person has questioned decision-making ability and consequently may not have legal capacity to provide informed consent to the assessment, the assessor may then seek consent from the older person's active, appointed decision maker (if they have one). In this

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circumstance, if the assessor cannot identify an active, appointed decision maker who has legal authority to consent to the assessment on behalf of the older person, the assessor may consider that the aged care assessment cannot be undertaken. Further information about the concept of capacity, including when an older person is considered to have questioned decision-making ability, is available in the *Capacity in the registered supporter context* policy document.

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

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

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

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

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

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

- If using the Consent Form, the assessor must record the informed consent in the My Aged Care Assessment Consent Form and upload it in the older person's record through the 'Attachments' function. The assessor can then use the 'Notes' section in the older person's record to:

    - indicate the signed form has been uploaded and consent given

    - record any detail the circumstances regarding any disclosure of an older person's personal information, and

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- record any instructions relating to the assessor's conversation on informed consent with the older person (and/or active appointed decision maker) and where relevant, any registered supporters.

- If a carer is identified for the first time during the assessment under the 'Carer profile' section of the IAT, the assessor must confirm with the older person that the older person has the carer's consent to provide the carer's telephone number and related personal information.

- Older people must be made aware that once consent for assessment is gained for the use and disclosure of personal information as authorised by the *Privacy Act 1988* (Cth) (Privacy Act), these records need to be retained in accordance with the *Archives Act 1983*.

- When seeking consent to make the older person's Support Plan available in their My Health Record (MHR), the assessor should ensure the older person understands that their GP, along with other authorised health professionals, will also be able to view their Support Plan on MHR. The assessor can make a note that the older person does not have to give their consent. They can also withdraw their consent at any time by contacting My Aged Care and requesting removal of their Support Plan from MHR.

Note:

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

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

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

**Federal Register of Legislation website**:

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

**Healthdirect website:** Healthdirect Privacy policy

**My Aged Care website:**

- Privacy Policy | My Aged Care

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- Registering a supporter | My Aged Care

## 5.2. Triaging assessments

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

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

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

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

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

### 5.2.1. Delegation to the Triage Delegate

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

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

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

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

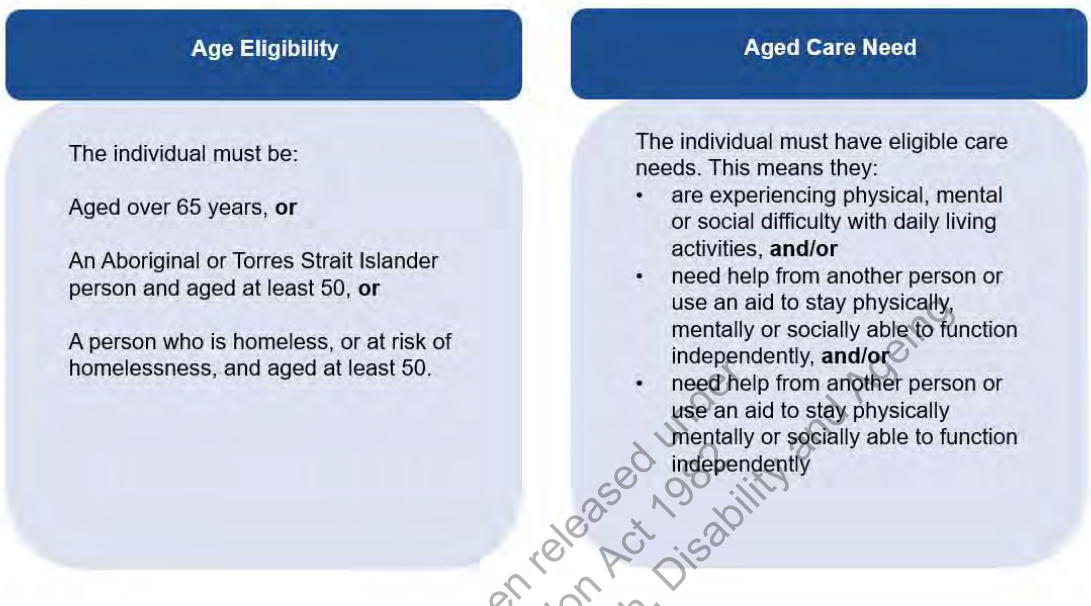



*Figure 2 - Eligibility requirements*

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

- the older person's date of birth, by checking with the older person, their registered supporter and/or active, appointed decision maker
- that the older person has declared they have care needs, noting this can be made by the older person through the registration and screening process or through a written statement from a person applying on the older person's behalf, or through written medical records (see section 58-5 of the *Aged Care Rules 2025*)
- for older people who have already been assessed at least once, the older person has had a significant change in circumstances and a reassessment is required. Significant changes are provided for in the *Aged Care Rules 2025* and include:
    - a carer for the older person has permanently ceased to provide some or all care to the older person;
    - the older person has experienced an event, or a decline in their condition, that is likely to mean that they will require:
        - more frequent access to a service they are already receiving, or
        - access to a service they have been approved for but are not currently accessing, or
        - access to new services not covered in the older person's access approval.

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

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

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

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

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

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

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

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

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

Important: older Aboriginal and Torres Strait Islander people may be members of the Stolen Generations and/or be impacted by displacement and social disruption and therefore may be traumatised by having to demonstrate their Indigeneity. If a person identifies as Aboriginal and Torres Strait Islander it is important for this to be documented during the assessment for eligibility, service and data collection purposes.

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

The assessment process for people who are homeless or at risk of homelessness between 50-64 years of age is the same process for assessing people aged 65 years and older. Under the Act, triage delegates will be required to inform people who are under 65

and seeking aged care services of alternative services that may meet their needs, prior to determining their eligibility (see section below). The person seeking assessment is not required to take up these services.

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

**Homeless definition**

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

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

**At risk of homelessness definition**

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

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

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

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

**Eligibility criteria assessment**

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

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

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

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## 5.2.4. Informing the eligible younger person of other services

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

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

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

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




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

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## 5.3. Conducting triage

Note

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

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

Review the older person's My Aged Care record

- Note the older person's preferences, choices, any additional needs and communication preferences that will need to be accommodated during the assessment process (e.g. when a hearing impairment is identified or an interpreter is required)
- Note that information will be pre-populated from screening. In some circumstances, if an older person was previously found ineligible, then later is eligible, the screening information cannot be changed. The 'likely ineligible' flag will be unticked however screening information will not be able to be updated.