FOI 27-3598 - Document 3

8.1.2. Best practice guides for decision-making

To support delegates in this role, the Administrative Review Council (ARC) has developed a series of Best Practice Guides. These guides serve as both a training resource and a reference tool for primary decision-makers in Commonwealth agencies, including Delegates. They cover key aspects of decision-making and provide practical guidance to help you make sound, evidence-based decisions.

You can refer to the five ARC Best Practice Guides on the Attorney-General's Department website.



ARC Best Practice Guides : Administrative Review Council publications | Attorney-General's Department

Note: The Administrative Review Council (ARC) published the Best Practice Guides prior to 2015. While they continue to be regarded as sound policy, it is important to note that they have not been updated to reflect any changes in case law or relevant legislation since their publication.

8.2. Quality assurance

Delegates play a crucial quality assurance role within the aged care needs assessment system. It is the delegate's responsibility to ensure that due process is followed. Delegates are responsible for ensuring that the person being assessed genuinely requires government-funded aged care services. Additionally, delegates must ensure that any missing information or gaps in the required evidence have been identified, followed up, and clarified with the assessor. This is essential to support accurate, well-informed delegate decisions and uphold the integrity of the assessment process.

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It is essential that assessment delegates maintain accuracy and consistency in their practice. Assessment delegates can do this by:

- Regularly consulting this Manual
- Adhering to the Aged Care Assessment Quality Framework to ensure continuous monitoring and enhancement of assessment practices in alignment with the Framework's goals.
- Seek guidance in situations that are complex or uncommon e.g. from a Team Leader, Manager, Workplace Trainer, or another assessment delegate who can provide appropriate support and clarification.
- Understanding and adhering to the legal requirements set out in the *Aged Care Act 2024)*.
- Completing mandatory refresher delegate training every two years through MAClearning.

FOI 27-3598 - Document 3

8.2.1. Validating the assessment process and evidence

To ensure evidence-based reasoning, and a commitment to fairness and accountability, it is essential that throughout the delegate decision making process assessment delegates:

- Validate the assessment process
- Review the assessment evidence

> Note: It is important that assessment delegates check that an individual's eligibility for an aged care needs assessment is thoroughly documented and supported by evidence. The Corrections and Reconsiderations sections in Chapter 11: Reviewable decisions, revoking eligibility or approval decisions and complaints, provide information on what assessment delegates should do if you have concerns about their eligibility for an aged care needs assessment.

8.2.2. Validating the assessment process

Assessment delegates must ensure that the correct assessment processes have been followed by the assessor. Section 62 of the *Aged Care 2024* (the Act) *Undertaking aged care needs assessments*, sets out how an aged care needs assessment must be completed and the key components it must include.

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In line with the Act, assessment delegates must confirm the assessment:

- Was completed by an approved aged care assessor.
- Was completed using the Integrated Assessment Tool
- Used the appropriate assessment tools.
- Has appropriately evidenced and aligned recommended funded aged care services with the older person's immediate care needs.
- Includes a discussion with the older person about:
    - What the assessment has identified in terms of funded aged care services.
    - How recommended aged care services may assist the older person to maintain their independence.
    - The older person's strengths and motivations in setting individualised goals.
    - The next steps in their application for funded aged care services.
    - Advising the older person how they will be informed of the outcome of their application, including the expected timeframe for receiving a notice of decision, and the support available to help them make appropriate linkages to services as required.
- Involves the registered support persons if this was required and requested by the individual.

Assessment delegates can find further detail and guidance regarding best practice for the above steps in Chapter 5: Assessment activities and Chapter 6: Aged care programs of this manual.

FOI 27-3598 - Document 3

Note: Supporting independence, autonomy, empowerment and freedom of choice. During the assessment, the assessor must ensure the individual they are assessing is aware of their rights under Section 23 Statement of Rights of the *Aged Care Act 2024* and support them to understand and empower them to exercise these rights.

8.2.3. Review the assessment evidence

Assessment delegates must ensure that all assessment information and documentation submitted by the assessor is accurate, relevant, and of high quality.

Assessment delegates must carefully examine the documentation to confirm:

- It provides a thorough and clear record of the entire assessment process.
- It demonstrates the assessor's reasoning.
- The evidence presented adequately supports their recommendations for aged care services.

Section 63 of the *Aged Care Act 2024* requires assessors to provide the assessment delegate with an accurate report of the assessment as soon as practicable after the assessment has been completed.

During the assessment, assessors are required to ensure all inputs into the IAT are accurate prior to finalising the IAT and submitting the assessment with the support plan to the assessment delegate for approval.

Assessment delegates must ensure that the assessment has been conducted correctly and that due process has been followed as outlined in sections 5.6 to 5.9 of this Assessment Manual. The assessment delegate must confirm that the individual being assessed genuinely requires government-funded aged care services, including identifying any missing information, inconsistencies, or gaps in evidence, and ensuring these matters are clarified with the assessor prior to making an access approval decision/s. This oversight supports accurate, well-informed, evidence-based delegate decisions and upholds the integrity of the assessment process.

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If the IAT or the support plan lack sufficient detail, contain errors, or include inconsistencies, assessment delegates may use the 'Return to Assessor' functionality to return them for amendment to the assessor via the Assessment Portal. When doing so, delegates must clearly outline the required amendments and ensure that appropriate quality assurance checks are completed.

System Functionality for returning the IAT and/or support plan to the assessor

Only an assessment delegate can return the IAT or support plan to an assessor for edits, using the '*Return to Assessor'* function in the Assessor Portal. The functionality to return the IAT is not available in the Assessor App. When an assessment is returned, any delegate decisions marked as '*agree'* or '*disagree'* in the support plan are removed and must be actioned again once the amended assessment is resubmitted.

Delegates may select one of the following 'Return to Assessor' options:

- IAT amendments and Support Plan amendments
- Support Plan amendments only

FOI 27-3598 - Document 3

The IAT can only be returned to an assessor once per assessment. However, the support plan may continue to be edited multiple times if required.

8.2.4. Assessment Delegate returning the support plan to the assessor for amendments

An assessment delegate may return the support plan to the assessor if the client's concerns and goals, service recommendations and assessment summary need amending before delegate approval. Returned assessments will display under 'Returned to assessor' in the Assessment Tab. Assessors are able to amend the client's concerns and goals, other recommendations, assessment summary and service recommendations according to the instructions provided by the delegate. Assessors must ensure all service recommendations are aligned with the IAT Outcome and 'Recommended Classification.'

Once the revised support plan and assessment is resubmitted for delegation, assessment delegates must conduct a final review to check that it meets the required quality standards before granting final approval. To support continuous improvement, it is expected assessment delegates provide assessors with constructive feedback that promotes best practice and helps them understand and meet documentation expectations.

8.2.5. Assessment Delegate returning the IAT to the assessor for amendments

Where the assessment delegate identifies errors in the IAT, they may return the IAT to the assessor to apply requested changes. This function can be used once per assessment. Using this function is appropriate where factual errors are identified by the assessment delegate, including:

- inconsistencies between responses across the different IAT domains,
- incorrect entry of information in comparison to a clients' assessment summary, support plan, or relevant reports and supplied evidence,
- missing or incomplete information relating to the client's circumstances, and
- insufficient detail within IAT responses, including free-text fields.

When returning the IAT to the assessor, the delegate must complete a notes field with a template that lists all IAT domains. This template is used to provide clear and specific instructions to the assessor. For each relevant IAT domain, the delegate must identify:

- the specific question(s) requiring correction
- the nature of the correction required (for example, updating a response, providing further detail, or adding missing information)
- any additional Validated Assessment Tools (VATs) that must be completed. Most VATs can be completed via telehealth or may also be completed face to face if able. The DEMMI and all Cognition VATs should not be completed via telehealth.

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FOI 27-3598 - Document 3

Assessor amending the IAT

Once the assessor receives the instructions from the delegate, they are required to action the requested changes in the relevant sections of the IAT. Refer to Appendix I of this Assessment Manual for further guidance on completing the notes template.

> Note: Clinical attendance remains vital and is still required as part of the assessment process. Non-clinical assessors must document all clinical supervisor(s) involved throughout the assessment process in the 'Notes to Delegate' section upon completion of the IAT amendments. Refer to section 5.7.1 of this Assessment Manual for further guidance on clinical attendance.

The assessor must also confirm all information is correct under each IAT domain, confirm that all goals were completed prior to completion of the IAT and then, select 'Finalise IAT,'

> Note: The system does not automatically return the updated IAT to the original delegate. Assessment organisations must have an internal process for assessors to notify the appropriate delegate when the IAT is ready for review. This process should also account for situations where the original delegate is unavailable (e.g. on leave) or where the required delegate type has changed following a new IAT Outcome (for example, from CHSP to SAH).

On finalisation of the IAT post-amendment, the system will generate a classification level for ongoing home support (referred to the IAT Outcome in the assessment workflow) which may be a Support at Home classification or CHSP level, or ineligibility for CHSP/SaH.

The new IAT Outcome may be higher or lower than the previous classification outcome, and if the intention is to recommend an ongoing Home Support Classification, the assessor must ensure the 'Recommended Classification' matches the new 'IAT Outcome' via the edit functionality (see 'Note' below for exception). If the assessor recommended a short-term pathway or 'ineligible for CHSP/SaH' for the purpose of recommending TCP and/or Residential care, this will remain displayed as the 'Recommended Classification.'

> Note: For existing clients already receiving Home Support, either with a Transitioned Home Care Package classification, or a Support at Home or CHSP classification, the new IAT Outcome may be lower than what they are currently receiving. Assessors must ensure that the 'Recommended Classification' is equivalent to their existing classification. Please refer to Table 2 in Chapter 1 of this Assessment Manual. Assessors may have to make manual edits to the 'Recommended Classification' if necessary.

As per existing functionality, the assessor can override the 'Recommended Classification' to recommend a short-term pathway or Residential Care if required. If the new IAT Outcome recommends a different pathway (e.g. CHSP to SaH ongoing), the 'Convert to Comprehensive Assessment' functionality will continue as per current functionality.

The assessor must ensure all service recommendations in the Support Plan align with the updated care pathways recommended once the IAT has been amended.

The assessor is required to document all amendments completed in the IAT in response to the delegate's instructions in a notes field template. Non-clinical assessors are required to include all clinical supervisor(s) that were involved throughout the completion of the

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FOI 27-3598 - Document 3

IAT. Assessment delegates must ensure that assessors have implemented all amendments to the IAT in accordance with the provided instructions, and that all required actions, including completion of an accurate Support Plan, have been completed as outlined above.

Delegate approval of the updated IAT

Once the assessment has been updated and re-submitted for approval, the Assessment Delegate will be able to action as per usual process. Assessment Delegates must ensure that assessors have implemented all amendments to the IAT in accordance with the provided instructions, and that all required actions, including completion of an accurate Support Plan, have been completed as outlined above.

When reviewing the client's Support Plan, the delegate will be able to view both the old and the new IAT Outcome which will display under the IAT Outcome and classification section. They will also be able to view the notes recorded by the assessor when the assessment was submitted for delegation. Once the algorithm has produced the new IAT Outcome, the new or amended outcome must be used for the assessment or support plan. The previous outcome cannot be selected or used.

Once the delegate has recorded their decision and actioned as required, the assessment will flow back through to the assessor for finalisation as per existing process.

All information in both notes fields from the assessor and delegate will not be available after the assessment is finalised.

For further guidance on this process, refer to the *Assessor Portal User Guide 7, 10* and Appendix I of this Assessment Manual.

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8.2.6. Assessment information and evidence

Assessment information and evidence should include all relevant documentation that supports the recommendations and decisions made throughout the assessment process. The assessment documentation must include:

- Consent
- Integrated Assessment Tool and Validated Assessment Tools
- Emergency Residential Care - Application for Care Form (where applicable)
- Additional Evidence
- Support plan and Recommendations
- Referral Information

Assessment Delegates must ensure that the assessment information contains comprehensive information to support the justification of the assessor's recommendation for funded aged care approvals. The following sections provide further detail on the requirements and how to ensure the evidence is sufficient.

FOI 27-3598 - Document 3

Support plans

Under the *Aged Care Act 2024* (the Act), two key types of reports are required when assessing an individual's eligibility and needs for aged care services: the Assessment Report (as per Section 63) and the Classification Report (as per Section 77).

In practice, these reports comprise the support plan and the finalised Integrated Assessment Tool (IAT) respectively.

The support plan and its associated areas of concern, goals, and recommendations are among the most important pieces of needs assessment documentation available to the Assessment Delegate. The support plan helps determine whether to approve an individual for access to aged care services and must contain all relevant information from the older person's aged care needs assessment.

It is essential that the assessment summary is written clearly and succinctly, following the ISBAR format–Introduction, Situation, Background, Assessment, and Recommendation in Chapter 5: Assessment activities.

Particular emphasis should be placed on the Assessment section, as it typically forms the most substantial part of the summary. This section should comprehensively detail the findings of the assessment, providing a clear and accurate reflection of the individual's needs and circumstances.

The support plan must be consistent with the information collected using the IAT and any other relevant information gathered during the assessment, such as GP health summaries. The assessment summary should clearly inform the goals, recommendations, and any areas of concern outlined in the support plan. These elements should reflect what the person is concerned about, what they hope to achieve or change, and how funded aged care services can support them in addressing their needs and aspirations. Any cultural considerations or preferences expressed by the older person during the assessment or identified through the information gathering process should also be captured within the support plan to ensure culturally appropriate services are delivered. E.g. Whether older Aboriginal and Torres Strait Islander people would like to receive services from First Nations providers.

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It is crucial that support plan recommendations are not just presented as a list of needs without context or explanation. Instead, the document should include clear elaborations on how each identified need was assessed and how this assessment informs the recommended care interventions or services.

When reviewing a support plan, assessment delegates should consider the following questions to ensure the documentation is thorough and meaningful:

- **Why is the person having a needs assessment?** - The support plan should clearly articulate the purpose of the assessment. Look for background information that explains the circumstances leading to the referral and the rationale for undertaking the assessment.
- **What are the older person's identified needs?** - Confirm that the support plan provides a comprehensive and evidence-based description of the older person's needs. This should encompass physical, medical, psychological and social domains as identified through the IAT and other validated assessment tools.
- **What types of support are required, and why?** - Ensure the support plan outlines the specific supports recommended along with a clear justification for each. These should be directly linked to the older person's assessed needs and supported by relevant evidence.

FOI 27-3598 - Document 3

- **What barriers are limiting the older person's independence?** - Assess whether the support plan identifies any factors, such as cognitive impairment, physical limitations, or safety risks; that prevent the older person from performing tasks independently. These barriers must be clearly connected to the recommended supports and services.
- **What are the older person's concerns and priorities? -** Ensure the support plan accurately reflects the older person's concerns, perspectives and priorities. These may relate to safety, daily living, mobility, or social participation and should be acknowledged and addressed appropriately.
- **What goals does the older person wish to achieve with support?** - Verify that the support plan includes the older person's goals and desired outcomes. Ensure recommended supports align with these goals and demonstrate respect for the older person's autonomy, preferences and aspirations.
- **Are the recommended supports appropriate and proportionate? -** Evaluate whether the recommended services are reasonable, tailored to the older person's current circumstances and likely to achieve the intended outcome.

Once finalised, the support plan is sent to the older person, and their registered supporter/s and/or appointed decision makers as applicable, as a record of the assessment, accompanied by a Notice of Decision letter. Registered providers also use the support plan to inform the individual's care plan, therefore accuracy and clarity essential.

Referral information

The support plan will contain referral codes for services that have been approved and listed in the Notice of Decision letter, except where the referral code has not yet been issued.[6] or used to action a referral. Referral information is a vital component of the older person's record and typically consists of documents and notes gathered from various sources during the initial screening, triage, and assessment process.

In most cases, referral information will be attached to the older person's record or documented as 'client notes' within the My Aged Care assessor portal.

It is essential to use referral information when making a decision, as it provides important context and justification for any recommendations made.

Record of consent

Assessment Delegates must ensure that consent has been properly recorded in the system before making any approval decisions.

Consent is a mandatory part of the assessment process and must reflect that the older person—or their appointed decision-maker recognised under the Act—has agreed to the assessment and referral to services. This protects older person's rights and ensures decisions are made in accordance with legislative and procedural requirements.

Application for Care form

Older people seeking access to funded aged care services will not be required to complete an Application for Care Form. The act of applying for access to services will commence

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[6] At the time of delegate approval, the referral code will not yet be available when the older person is awaiting funding through the Support at Home, AT or HM Priority Systems.

FOI 27-3598 - Document 3

through one of the existing registration pathways (i.e. the My Aged Care contact centre or Aged Care Specialist Officers).

However, older people seeking access to residential care and emergency respite care will be required to complete an *Emergency Residential Care - Application for Care Form*. This form is used by providers and must be completed and uploaded to the older person's My Aged Care Record, to confirm when they commenced receiving services.

Triage Delegates must review the form for completeness and be satisfied that the requirements under s58 are met. The Assessment Delegate is responsible for reviewing and approving the application form.

See the section titled *Further guidance Application process for people who have received aged care services but not yet applied for an assessment under My Aged Care* at the end of this chapter for more information.

Integrated Assessment Tool (IAT) and Validated Assessment Tools (VaTs)

The IAT and its VATs is the prescribed tool that assessors must use under s62-5 of the Rules. The IAT is essential for capturing a comprehensive profile of an older person's needs, ensuring accuracy and consistency in decision-making. The IAT consolidates key information about an older person's needs across a number of domains, providing a holistic view of their health and circumstances. Additionally, embedded validated tools assess abilities and capacity, forming a solid evidence base for determining care needs.

Assessment delegates must evaluate the information captured in these tools to determine an older person's eligibility for aged care services. This means cross-referencing the assessor's recommendations with the data recorded in the IAT to ensure the decision aligns with the support plan and matches the level and type of care identified during the assessment process.

If assessors choose to use any additional VATs beyond the IAT, assessment delegates must ensure they are uploaded as attachments to the 'client record.' This is essential for maintaining complete documentation.

Additional evidence

Assessment evidence can come from a range of sources, including letters or emails from health professionals such as geriatricians, GPs, or social workers. Additional useful documents might include written information from family or friends, GP medical summaries, completed AT-HM tier guide, hospital discharge summaries, and correspondence from current service providers, Care Finders, Elder Care Support workers, government or non-government agencies, or others involved in the older person's care. These documents offer valuable insights into the older person's needs and may help identify the type and urgency of required care and support.

Assessment organisations may also hold regular delegation meetings to review assessed individuals and ensure a multidisciplinary approach has been applied. These meetings help guide assessors in making well-informed recommendations before support plan submission and support assessment delegates, in fully understanding an individual's aged care needs, enabling accurate and informed decision-making.

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FOI 27-3598 - Document 3

> Note:
>
> If Assessment Delegates have any concerns about the quality or completeness of the evidence provided, it is important they discuss these with the assessor before proceeding with approvals. Assessment Delegates may also involve a manager or team leader in this discussion, if necessary, to ensure that all aspects of the assessment are properly addressed.

8.3. Approving home support

8.3.1. Step 1. Decide if the older person is eligible for home support

Before approving a recommendation for the home support service group, the Assessment Delegate first needs to decide if an older person requires and is eligible to access this service group. Please refer to section 7.6.1 Deciding if the older person requires aged care services and section 7.6.3 Section 67 – a person who has an impairment or sickness.

During the assessment, once the IAT is finalised, the IAT Outcome will generate a recommendation for the older person to receive ongoing home support through the Commonwealth Home Support Program (CHSP) or Support at Home (SaH). It may also recommend 'ineligible for CHSP/SaH.' As such, the IAT Outcome will guide the Assessment Delegate to determine whether the older person is eligible for ongoing home support through CHSP or Support at Home.

> Note: An IAT Outcome of 'ineligible for CHSP/SaH' means that the older person has not met the minimum threshold to receive ongoing home support through CHSP or Support at Home.

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8.3.2. Step 2. Decide the classification type and level

The IAT Outcome includes a service group (care type), classification type (duration) and classification level (funding). For example, a person who has been assessed as needing access to ongoing home support services under Support at Home, the approval will be the following:

- **Service group:** Home support
- **Classification type:** Ongoing
- **Classification level:** SAH class (1 to 8)

Section 81-10 of the *Aged Care Rules 2025* provides criteria that an older person must meet to be approved access for ongoing home support through CHSP or Support at Home. These criteria are based on a defined set of rules that has been built into the IAT to generate the IAT Outcome. This means that the IAT Outcome will determine whether the older person meets the criteria in section 81-10 of the Rules and the classification level (funding) for ongoing home support.

FOI 27-3598 - Document 3

Chapter 5 provides guidance to assessors to accept the IAT Outcome if they are intending to recommend ongoing home support services through CHSP or Support at Home. Before approving any recommended classification level, assessment delegates must ensure that the classification level recommended by the assessor is the same as the classification level generated by the IAT Outcome. The system-generated recommendation is labelled 'IAT Outcome,' and the assessor's recommendation is labelled 'Recommended classification.' If these two values are different, then the assessor has overridden the IAT Outcome.

In instances where the assessor has overridden the IAT Outcome to another ongoing home support classification (e.g. SaH class 4 to SaH class 5, CHSP to SaH class 1, 'ineligible for CHSP/SaH' to CHSP), the delegate must disagree with the assessor's recommended classification level and edit it to the classification level recommended by the IAT Outcome.

Note:

It is necessary for the assessor to override a CHSP/SaH classification (or accept in the case of an 'ineligible for CHSP/SaH) generated by the IAT Outcome to recommend the following pathways:

- SaH Restorative Care Pathway,
- SaH End-of-Life Pathway.
- Transition Care Program without ongoing in-home services,
- Permanent Residential Care without ongoing in-home services,
- Residential Respite care without ongoing in-home services.

Assessors may also approve an ongoing home support classification (SaH) alongside TCP and Residential Care and select 'not seeking services' to avoid a reassessment being required for the older person.

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Approving CHSP services alongside Support at Home classifications

Under the *Aged Care Act 2024* (the Act), an older person cannot be approved for the Commonwealth Home Support Program (CHSP) class at the same time as any Support at Home (SaH) classification level (SaH class 1-8, SaH Restorative Care Pathway or SaH End-of-Life Pathway).

In limited circumstances, SaH participants can access additional CHSP services and assessors can issue referrals for CHSP services for individuals with a SaH classification.

See tables 29 and 30 in Chapter 6 for further details about when an individual with a Support at Home classification can be approved to access CHSP services.

Approving the SaH Restorative Care Pathway

Each financial year, 20,000 Restorative Care units of funding will be available nationally, distributed across four quarters at approximately 5,000 units per quarter. These units of funding are limited and must be carefully allocated to ensure the pathway remains sustainable and appropriately targeted to individuals with short-term restorative care needs. Assessors will be able to recommend Restorative Care Pathway (RCP) regardless of the caps on units of funding. The Assessment Delegate may not approve this recommendation if RCP units of funding have run out.

For SaH participants receiving ongoing services at the time the RCP is approved, the RCP episode can be accessed concurrently with their ongoing services. This allows individuals to continue using their ongoing services while also receiving additional, clinically focused services through RCP.

However, it is important to ensure that services provided under RCP are complementary to ongoing services. The restorative care partner and ongoing care partner should ensure coordination of services to achieve this.

Services delivered through RCP should focus on reablement and allied health and/or nursing interventions—aimed at improving function and independence, rather than duplicating routine or maintenance care.

For those already accessing ongoing care, assessors should carefully consider ongoing needs before recommending RCP. Assessors cannot recommend a new higher classification and the RCP at assessment. This will impact a new ongoing classification entry into the SaH Priority System.

For new individuals being assessed for SaH and considered for RCP, eligibility for ongoing services will need to be determined at the end of the RCP episode. Individuals cannot be simultaneously approved for both RCP and an ongoing SaH or CHSP classifications at the time of assessment.

When selecting the RCP, an assessor will not be able to select a new ongoing classification.

For those accessing ongoing services, an assessor may select a new ongoing SaH classification **or** RCP. If RCP is selected, the person will automatically retain their current classification.

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Note:

The IAT will allow a CHSP classification to be overridden to RCP during a comprehensive assessment. However, assessors must **not** undertake this action and delegates must not approve assessments where this occurs. Where a CHSP classification outcome is generated, RCP cannot be recommended for approval (in line with section 81-15 of the Aged Care Rules.) An ongoing SaH classification must be generated by the IAT to override and recommend RCP for approval.

To recommend the RCP classification, the individual must have received an initial ongoing SaH classification through the IAT Outcome. This is then overridden by the assessor to recommend the RCP.

Participants assigned to the RCP who have an assessed need for AT and / or HM will be allocated AT-HM funding immediately.

After a restorative care episode, a participant will undertake a reassessment to get approval for an ongoing classification and be placed in the SaH prioritisation system, if required.

FOI 27-3598 - Document 3

Approving restorative care - guidance for assessment delegates

An assessment delegate is responsible for approving access to the RCP. The assessment delegate can only approve someone for RCP if all eligibility criteria are met. They may consider if places are available for allocation. The assessment must clearly show that the individual is likely to benefit from short-term, multidisciplinary allied health and/or nursing support aimed at improving their function and independence. An assessment delegate must make sure that their decision is backed by appropriate evidence.

> Note: To be approved for the RCP, the older person must not be in hospital or residing in permanent residential care at the time of the assessment. The older person must be residing in the home or community setting.

The assessment delegate is also responsible for making sure all decisions follow pathway rules, including:

- The person has not already been approved for two units of funding for Restorative Care in the past 12 months.
- It has been 90 days from the maximum period of effect from a previous episode of Restorative Care.
- For the relevant transition period, delegates should also confirm if a person has accessed RCP through a Short-term Restorative Care (STRC) approval to determine eligibility for further RCP funding units.

If an additional unit of funding is requested through a support plan review (SPR), the assessment delegate must ensure that the documentation clearly explains the reason, how it links to the person's goals, and that evidence is provided to support your decision. The assessment delegate's role in reviewing and approving these cases is essential to making sure the RCP is used fairly, consistently, and in line with the pathway's goals of early intervention and reablement. Availability of RCP units may also be considered.

If the participant is accessing two separate episodes of restorative care, they will need to wait at least 3 months from the end of the 16 weeks period associated with the original episode before being eligible to receive a second episode within the 12-month period.

An RCP recommendation may not be approved if there are no RCP places available for allocation. The assessor may contact the older person to discuss alternative supports for recommendation.

> Note: Decisions made about RCP through the IAT are made under s65 and s78 which are reviewable decisions under the Act. Decisions made about the additional unit of Restorative Care Pathway funding through an SPR are made under section 195-3 of the Rules and are not reviewable.

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FOI 27-3598 - Document 3

Eligibility considerations and exclusions

An individual **cannot** access the Restorative Care Pathway (RCP) if they:

- Are receiving, or are eligible to receive, the End-of-Life Pathway
- Have been approved for two episodes or two separate units of Restorative Care funding within the past 12 months or have recently accessed Restorative Care (a 90 day gap is required from the end of the 16-week period associated with the first episode of care).
- Are receiving, or are eligible to receive, services under the Transition Care Program
- Are in permanent residential aged care.

Individuals who have been approved for the RCP may access services through Multi-Purpose Services Program or National Aboriginal and Torres Strait Islander Flexible Aged Care Program, if eligible for those programs and in-line with program rules.

Assessment delegates should be aware when a client who has an ongoing SaH classification and is reassessed for the RCP there is no impact on the person's current ongoing SaH classification or position in the SaH Priority System. A new ongoing SaH classification and RCP are unable to be recommended at the same time. Assessors and Assessment Delegates should consider a person's current ongoing needs before recommending the RCP episode. If an older person needs a new ongoing classification, they will need to be reassessed following the RCP episode.

Manual oversight of restorative care places

RCP places are capped at 20,000 units per year, managed as around 5,000 units per quarter. From 1 November 2025, system-based visibility of Restorative Care units will not be available. As a result, there will be no in-system prompts or controls to prevent the approval of RCP funding units beyond the quarterly caps. Weekly reports of approvals made will be generated, allowing the Department to monitor RCP approvals and communicate with assessment organisations when approvals approach or exceed the assigned caps.

In addition to RCP approvals confirmed after 1 November 2025, those with an active Short-Term Restorative Care (STRC) approval (who did not start STRC before 1 November 2025), will have their approvals transferred into an approval for RCP.

Note for this cohort using their STRC approval to access the RCP: they will also be accessing the RCP units of funding for the first six months from 1 November 2025.

A second unit of funding to use within a single RCP episode can be requested via a support plan review (SPR) request noting the assessor will need to self-refer this for reassessment to grant access to a second unit of funding (see Chapter 6).

The decision to approve a second unit will be informed by evidence submitted by the provider with the SPR request. Availability of the RCP funding units may also be considered. When a request for a second unit of RCP is received assessors should confirm if there is approval for STRC and RCP on the client's record. If there is approval for both, the assessor will need to confirm with the client if they entered care under the RCP after 1 November 2025 using the STRC approval. If this is the case, then the assessor must not approve a third unit of RCP funding.

If the participant is eligible to access an additional restorative care pathway they must wait at least 12 months before accessing another episode.

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FOI 27-3598 - Document 3

Assessment delegates will need to remain acutely aware of any communication from the department regarding RCP caps to ensure they are making informed decisions. These communications will be the **primary tool** for identifying when the allocation of RCP units are close to being fully utilised. Being responsive to these insights is essential for maintaining compliance with pathway limits and avoiding over-allocation.

Restorative care funding

The Restorative Care Pathway (RCP) provides around $6,000 of funding (one unit), for up to 16 weeks. The total amount of funding a participant uses and length of time to complete an episode can differ. Restorative care partners will consider this when developing the goal plan.

At times, participants with higher needs may require additional funding over and above the $6,000 allocated per episode. If the participant requires additional funding within a single 16-week episode, the provider can submit a request for a support plan review. If certain circumstances are met, approval can be given for the additional $6,000 in funds to support the episode.

If approved, a participant can access an additional unit of funding (up to $6,000), to provide a combined total of up to $12,000 (two units), for a single episode of restorative care. If additional funding is approved, a participant will not be eligible for a further episode of restorative care within a 12-month period as they have accessed the maximum 2 units of funding within the first episode.

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Important:

- The decision to approve additional concurrent funding to the RCP episode is made under subsection 195-3 of the *Aged Care Rules 2025 (the Rules)*. It is a non-reviewable decision. The criteria in the Rules includes that required evidence must be given by the participant's provider and there must be units of funding available for approval.
- The assessment delegate must send a letter to the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) notifying them of the outcome of the application for the additional funding.

Approving the End-of-Life Pathway

The End-of-Life (EoL) Pathway is one of the short-term home support classifications under the Support at Home program. It provides 12 weeks of funded support at around $25,000 for older people who are medically assessed to have three months or less to live and have an Australian-modified Karnofsky Performance Status score of 40 or less. The pathway is designed to enable people to remain at home with appropriate care during their final stage of life.

End-of-Life Pathway form

The End-of-Life Pathway form is used to document the required medical evidence for accessing the End-of-Life Pathway under the Support at Home program. An individual seeking access to the End-of-Life Pathway must complete all relevant sections and present this form to a medical practitioner or nurse practitioner for completion. The completed form should then be submitted as part of the assessment process—either before or during triage, or assessment—and reviewed to confirm eligibility for the End-of-Life Pathway.

FOI 27-3598 - Document 3

The assessment delegate is responsible for verifying the completion of this form in the older person's record when the End-of-Life Pathway has been flagged in the My Aged Care assessor portal.

Reviewing the form will involve:

- Checking the individual's details to ensure they match the record in the portal.
- Verifying the completion of all areas of the Medical Assessment section to confirm
    - The individual has a prognosis of a life expectancy of three months or less, and
    - An Australian-modified Karnofsky Performance Status (AKPS) score of 40 or less.
    - Medical practitioner or nurse practitioner has completed and signed the form.

An individual will **not** be eligible for approval for the End-of-Life Pathway if the required criteria outlined in the medical assessment section are not met.

8.3.3. Step 3. Decide the service types and services

Older person is Aboriginal and Torres Strait Islander

If the older person is an Aboriginal or Torres Strait Islander person, the *Aged Care Act 2024* (the Act) provides that they only need to be approved for one or more service groups. That is, under the Act they are automatically approved for all the service types and services in any service group they are approved for. However, an Assessment Delegate will still need to make sure that all the service types and services they are approved for are selected in the system (more guidance on this follows below).

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Older person is neither Aboriginal nor Torres Strait Islander

If the older person is not an Aboriginal or Torres Strait Islander person, and an Assessment Delegate is approving the Home Support, Assistive Technology or Home Modifications service groups, they must decide:

- which service types to approve them for within each service group
- which services to approve them for, but only if the Assessment Delegate is approving the following 'prescribed' service types: *Allied health and Therapy* and *Therapeutic Services for Independent Living.*

For any service type other than *Allied health and Therapy* and *Therapeutic Services for Independent Living* (the 'non-prescribed' service types), if an Assessment Delegate thinks the older person needs any service in the service type, then they need to make sure that all services in the service type are selected.

Check to make sure the required services are selected

The system currently allows services to be de-selected in the non-prescribed service types, which leaves open the possibility that services the person is actually entitled to are left out.

FOI 27-3598 - Document 3

Assessment delegates need to carefully check to make sure that the all the required services have been selected. This is particularly important for any approvals given under CHSP, as the services under the service type are not pre-selected in the system.

Recording the decision for Support at Home classes (ongoing and short-term)

This process applies if the approved classification level (labelled 'classification' in the system) is any of the following:

- SAH class 1 to 8
- SAH Restorative Care Pathway
- SAH End-of-Life Pathway.

> Note:
>
> The Support at Home AT-HM scheme is referred to as a 'short-term pathway.' Under the Act, the AT-HM scheme is enabled through the Assistive Technology and Home Modifications service groups. AT-HM can be added to an older person's support plan, if there is an assessed need, after adding one of the ongoing or short-term Support at Home classifications above.

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Review CHSP service recommendations

Assessment delegates should review any CHSP service recommendations listed. If they disagree with any of them, they should contact the assessor to discuss and amend the list if required.

Assessment delegates are able to record their agreement or disagreement alongside each CHSP service recommendation in the assessor portal. An assessment delegate's decision to agree with the recommended CHSP services will be automatically recorded in the Notice of Decision.

8.3.4. Step 4. Confirm the priority category

Access to the ongoing Support at Home classifications (SAH classification 1 to 8) will be prioritised using information collected during the assessment process and on the client's record, through the Support at Home Priority System.

An older person's priority category is determined by the prioritisation algorithm based on a standardised set of seven criteria. The seven criteria have 'points' allocated to them, and how many points an individual has determines their eligibility for a priority category of Urgent, High, Medium, or Standard.

The AT-HM scheme has its own priority systems, and these are described further under the section *Approving AT and HM under Support at Home*, below.

FOI 27-3598 - Document 3

The seven criteria captured in the IAT or on the client's record that calculate the Support at Home priority category are whether the person:

1. lives alone (1 point)
2. identifies as Aboriginal or Torres Strait Islander (1 point)
3. has an assessed cognitive impairment (1 point)
4. is experiencing homelessness or is at risk of homelessness (1 point)
5. requires urgent ongoing service provision (2 point)
6. waited more than six months between assessment referral and completion and lives in a rural or remote area (in a Modified Monash Model category 5, 6, or 7 area) (1 point)
7. has Motor Neurone Disease (MND) (5 points)

Assessment Delegates should check the responses to the seven fields above to make sure that the correct inputs are recorded.

> Note:
>
> Assessment delegates will not know the priority category until after they click the 'Save and Delegate' button in the portal.

The four priority categories are as follows:

Table 47. Priority categories for ongoing Support at Home classifications

Urgent	The older person has five or more points.
High	The older person has four points.
Medium	The older person has two or three points.
Standard	The older person has one or no points.

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The priority category will be displayed under 'Approvals for a Client' in the Assessor Portal.

The system will automatically recalculate an older person's priority category (if required) when changes are made to the following fields in their client profile:

- Accommodation type
- No fixed address
- Lives With
- Aboriginal and Torres Strait Islander Status

FOI 27-3598 - Document 3

8.3.5. Step 5. Confirm service seeking status (ongoing Support at Home classifications only)

As part of the assessment process, assessors are expected to have a clear conversation with the individual about whether they are seeking to receive services through the Support at Home program. This helps ensure the individual's current needs are met and supports fair and timely access to services for others. When individuals who are not actively seeking services through the Support at Home program remain on the Support at Home Priority System, it can cause delays for those who are ready and actively seeking services.

Before referring the client for services, the assessor should confirm with the client if they wish to seek home support from the Support at Home program and record their preference in the support plan:

- For clients seeking to access their ongoing home support through the Support at Home program, the assessor should set the service seeking preference for the ongoing SaH classification to 'seeking services'
- For clients not seeking to access their ongoing home support services through the Support at Home program, the assessor should set the service seeking preference for their ongoing SaH classification 'not seeking services.' The assessor should do this for clients who choose to access services through NATSIFACP or MPSP and so do not require services from a Support at Home provider. This option makes sure the client does not enter the Support at Home Priority System and so is not allocated funding under Support at Home.

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If the older person later wants to use their ongoing SaH classification through the Support at Home program, they can change their preference and enter the Support at Home Priority System. Their wait time will be counted from their original access approval date of effect. That is, it will be as if they had stayed in the queue from their first approval. They can change their preference by:

- contacting My Aged Care
- using the My Aged Care Online Account.

Assessment Delegates are responsible for confirming that the client's preference–whether to seek or not seek services through the Support at Home program–has been accurately recorded in the support plan and that it aligns with their assessed needs.

8.4. Approving Assistive Technology and Home Modifications under Support at Home

This section relates to approving Assistive Technology (AT) or Home Modifications (HM) under the AT-HM scheme. The AT-HM scheme is one of the short-term pathways of the Support at Home (SaH) program. To be approved for the AT-HM scheme, the older person must also be approved for home support with a SAH classification level. A later section will show how to approve AT or HM when the classification level of the older person is *CHSP class*.

FOI 27-3598 - Document 3

8.4.1. Step 1. Decide if the older person is eligible for AT or HM

Before approving a recommendation for AT and/or HM, an Assessment Delegate first needs to decide if an older person requires and is eligible to access one or both of these service groups.

Existing questions in the IAT will help to identify and determine an older person's need for AT or HM. For example, the purpose of the function section is to understand a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

As part of an Assessment Delegate's decision-making, they must consider whether the older person:

- has needs and goals that could be met through using assistive technology or home modifications, or both
- can have those needs met through the assistive technology or home modifications service groups, and therefore the products, equipment and home modifications on the AT-HM list.

8.4.2. Step 2. Approve the classification type and level (funding tier)

Assessment Delegates are responsible for approving the classification type (ongoing or short-term) and funding tier for AT and HM recommended by the assessor. Once approved, funding must be used within the 12-month period (in most instances).

A 'funding tier' for AT-HM has been implemented as a 'classification level' under the *Aged Care Act 2024* (the Act). These funding tiers determine the maximum budget (except for AT high tier where there is no maximum budget) available and are valid for 12 months (in most instances) from the date the individual started care with their provider (as notified by the provider in the start notification for the person).

Individuals can access AT ongoing (assistance dogs) and short-term and HM tiers concurrently if needed and may be required to contribute financially depending on the category of support.

The cost of prescription and wrap-around services—such as delivery, setup, training, and follow-up—are also drawn from the AT-HM funding tier. Providers may charge:

- up to 10% of the cost of the item or item bundle or up to $500 (whichever is lower) on administration costs for AT.
- up to 15% of the total quoted cost of a participant's home modification or up to $1,500 (whichever is lower) on coordination costs for HM.

The AT-HM funding tier must align with the individual's assessed needs and be documented in their support plan. An Assessment Delegate's approval ensures appropriate funding allocation, program compliance, and timely access to essential supports.

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Assessment Delegates must consider the costs of prescription and wraparound services when approving a funding tier.

An individual is not eligible for the AT-HM scheme if they are currently receiving permanent residential aged care.

AT-HM scheme funding tiers

If AT or HM are approved, individuals will be assigned a funding tier for AT, HM, or both - based on their assessed needs.

Table 48. Funding tiers for both AT and HM: Low, Medium and High

Indexation will be applied to the below amounts; indexation will occur on 1 July and 1 August 2026. For the latest budget information, please go to: Schedules of Subsidies and Supplements for Aged Care | Australian Government Department of Health, Disability and Ageing

Funding tier	Funding allocation cap	Funding period
Assistive technology		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000[1] (nominal)	12 months
[1] Participants can access more than $15,000 with a prescribed need.		
Home modifications		
Low	$500	12 months
Medium	$2,000	12 months
High	$15,000	12 months[2]
[2] Funding may be extended for an additional 12 months to complete complex home modifications (24 months in total) if evidence is provided to Services Australia		
Other funding		
Assistance dog maintenance	$2,000 per year	Ongoing[3]
[3] Funding for assistance dog maintenance will be automatically allocated every 12 months; however, the funding cannot accrue or rollover.		

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An AT-HM tier guide has been developed to assist assessors to make a funding tier recommendation for assistive technology and/or home modifications based on the older person's assessed need in the IAT. This includes considering their current functional ability and home environment. The guidance has been designed to consolidate the main elements of the IAT relevant to AT-HM to support assessors in choosing a funding tier. The guide will

FOI 27-3598 - Document 3

suggest a funding tier which should sit where the majority of tier indicators have been selected. Assessors should ensure their recommendations align with the participant's goals, safety, independence, and overall ability to remain living at home. They may choose to select an alternate tier if funding does not align with assessed need. Assessors can upload the document as an attachment to allow Assessment Delegates to review as supporting evidence for any funding tier recommendations made.

The assessment delegate may also use the completed AT-HM tier guide, uploaded by the assessor, to review evidence related to the decision making process on allocation of a particular AT or HM funding tier.



See APPENDIX G – AT-HM terms for further information regarding the AT-HM Terms and Chapter 6: Aged care programs for AT-HM case studies

AT-HM list

The AT-HM list sets out the equipment, products and home modifications that are available for Support at Home participants under the AT-HM scheme. The AT-HM list sits under the main Aged Care Service list, which lists all other services and service types.

The list was constructed using the internationally agreed instruments and Australian-adopted AS/NZS ISO Assistive Product- classification and terminology standard (2023) and informed by subject matter experts.

Participants may use their AT-HM scheme funding on items listed under 'Inclusions' where an assessed need is documented in their support plan. Conditional inclusions are subject to additional criteria.

Home modification items are included on the AT-HM list. Services associated with the sourcing, supply and provision of the home modification products on the AT-HM list, such as installation, fitting, council approval and planning, will also be funded through the AT-HM scheme.

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The AT-HM list includes the following categories:

- managing body functions – including pressure cushions, anti-oedema stockings and memory support products
- self-care products – including adaptive clothing or shoes and assistive products for toileting, bathing and showering
- mobility products – including walking frames, wheelchairs and lifting devices
- domestic life products – including assistive products for food preparation, eating, drinking and house cleaning
- communication and information management products – aids that assist with reading and writing, as well as alternative and augmentative communication (AAC) devices
- home modifications - including accessible showers, grabrails, fixed ramps and safety barriers.

FOI 27-3598 - Document 3

The AT-HM list

The AT-HM scheme guidelines

8.4.3. Step 3. Confirm the priority category

The AT-HM scheme has separate priority systems to the Support at Home Priority System, as the funding is separate. The AT-HM scheme has an Assistive Technology Priority System and a Home Modifications Priority System that allocate AT and/or HM funding. An older person assessed as eligible for AT and/or HM will enter the AT-HM Priority Systems in one of its three priority categories (high, medium, standard). The older person will not be able to access AT-HM under Support at Home until funding has been allocated. The amount of time they wait for services will depend on the priority category they are in.

Older people receiving AT or HM funding under EoL or RCP will be a high priority and have their funding immediately allocated.

The AT-HM Priority Systems ensure the equitable allocation of funding based on standardised criteria determined using information collected by the aged care assessor through the IAT.

The criteria captured in the IAT or on the client's record that calculate the priority category are:

1. Individual lives alone
2. Individual has an assessed severe mobility impairment
3. Individual is an Aboriginal or Torres Strait Islander person
4. Individual's current place of residence poses a severe risk to their health or safety
5. Individual has waited more than six months between assessment referral and completion and lives in a rural or remote area (in a Modified Monash Model category 5, 6, or 7 area)

Individuals who are being approved for the Restorative Care or the End-of-Life pathways under Support at Home will have immediate access to any AT-HM funding allocated. Note that the system will display an AT-HM priority of 'High' in this scenario, but the funds are allocated immediately. Further information is available in the AT-HM scheme guidelines.

Although the system calculates priority automatically, the Assessment Delegate should check the responses to the five fields above to make sure that the correct priority category is applied.

Note the priority category will not be displayed until **after** you click the 'Save and Delegate' button in the portal. The Priority Category will be displayed under 'Approvals for a Client' in the My Aged Care Assessor Portal.

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8.4.4. Step 4. Confirm service seeking status (AT-HM)

Assessment Delegates are responsible for confirming that the individual's preference—whether to seek or not seek AT-HM funding through the Support at Home program—has been accurately recorded in the support plan and that it aligns with their assessed needs.

Assessors are expected to confirm with the client if they wish to seek AT-HM funding from the Support at Home program and record their preference in the support plan.

- **For clients seeking AT and/or HM services through the Support at Home program**, the assessor should set the AT and/or HM service seeking preference to 'seeking services.' This ensures that the older person is placed on the AT and/or HM Priority System(s).

- **For clients <u>not</u> seeking AT and/or HM services through the Support at Home program**, the assessor should set the AT and/or HM service seeking preference to 'not seeking services.' This option makes sure the client **does not** enter the AT or HM Support at Home Priority Systems, and so is not allocated funding under the AT-HM scheme. Relevant circumstances include when:
    - the client has chosen to access services through NATSIFACP or MPSP and so they do not require services from a Support at Home provider (or funding from the Support at Home program)
    - the client does not want to access AT and/or HM services at this time.

There are separate AT and HM Support at Home Priority Systems with independent 'service seeking' statuses for each. This means that if the older person is approved for both AT and HM, they may seek services through the Support at Home program for one, both or neither.

If the older person later wants to access their AT or HM services through the Support at Home program, they can change their preference and enter the AT or HM Priority Systems. The older person will need to be a Support at Home participant (for ongoing home support) to do this. Their wait time will be counted from their original access approval date of effect. That is, it will be as if they had stayed in the queue from their first approval.

An older person can change their service seeking preference by:

- contacting My Aged Care
- using the My Aged Care Online Account

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> Note:
>
> Participants assigned to the Restorative Care Pathway or the End-of-Life Pathway who have an assessed need for AT and HM will be allocated AT-HM funding immediately.

FOI 27-3598 - Document 3

8.5. Approving AT and HM under CHSP

This section relates to approving AT or HM for an older person who are also approved for ongoing home support with a classification level of CHSP class.

8.5.1. Understanding AT and HM under CHSP

Under the *Aged Care Act 2024* (the Act), AT and HM services will continue to be available to older people under the CHSP. The relevant service types will be:

- **Home adjustments**: subsidised home modification services funding is capped at $15,000 per annum.
- **Equipment and products :** subsidised low-cost equipment and products with funding of up to $1,000 per year in total (not per item).

Under the Act, eligible people will be approved for:

- the home support service group with a classification level CHSP class, and
- the assistive technology service group with a classification level of AT CHSP or
- the home modifications service group with a classification level of HM CHSP.

There are no funding tiers for AT or HM under CHSP. The subsidy for AT is capped to $1,000 per year and up to $15,000 per year for HM.

8.5.2. Step 1. Decide if the older person requires AT or HM under CHSP

Before approving a recommendation for AT or HM, Assessment Delegates first need to decide if an older person requires and is eligible to access one or both of these service groups.

Existing questions in the function section of the IAT will help to identify and determine an older person's need for assistive technology or home modifications. The purpose of the function section is to understand a client's functional ability, their ability to complete activities of daily living, and if the client requires further assistance with these.

When reviewing the assessment and IAT, Assessment Delegates will need to consider whether the older person's:

- needs and goals that could be met through using assistive technology or home modifications
- can have those needs met through the services under Assistive Technology and Home Modifications

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FOI 27-3598 - Document 3

8.5.3. Step 2. Review service recommendations for AT or HM under CHSP

Service recommendations represent referrals that can be made through the Assessor Portal to Commonwealth-subsidised aged care services.

Review the service recommendation details for CHSP Assistive Technology and CHSP Home Modifications including:

- service type and service (sub-type) – if applicable
- start, end and review dates – if applicable
- frequency, intensity
- priority
- outcome.

8.6. Approving permanent residential care

8.6.1. Step 1. Decide if the older person requires ongoing residential care

Permanent residential care is delivered through the service group residential care and an access approval for the ongoing classification type. It is provided by registered providers in approved residential care homes.

Before approving a recommendation for residential care, Assessment Delegates first need to decide if an older person requires and is eligible to access this service group.

There is one key point to remember when deciding on access for non-Aboriginal or Torres Strait Islander people. **Section 68** of the *Aged Care Act 2024* (the Act) requires these older people to have a continuing need for funded aged care services because of sickness in order to access the residential care service group. Assessment Delegates need to be satisfied, that the person's sickness at the time of assessment means that they have a continuing need for residential care.

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8.6.2. Step 2. Confirm the priority category

To meet the requirements of the Act, an older person being approved for permanent residential care will be assigned a priority category (1, 2 or 3). The priority category is not currently being used to prioritise access to residential care.

FOI 27-3598 - Document 3

Table 49. Priority categories for permanent residential care

Category #	Description
1	The person: • has a high urgency rating; or • resides in a rural or remote area classified as MM 5, MM 6 or MMM 7; or • is Aboriginal or Torres Strait Islander, homeless, or is entering residential care due to emergency circumstances.
2	The person does not meet the criteria for Priority Category 1 and has a medium urgency rating.
3	The person does not meet the criteria for Priority Category 1 and has a low urgency rating.

The priority category is automatically generated by the assessor portal based on the individual's circumstances, urgency rating and in accordance with the criteria specified by the *Aged Care Rules 2025* (the Rules).

Assessment Delegates need to verify that the urgency rating assigned to the individual accurately reflects their needs and are supported by the evidence provided.

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8.6.3. Urgency rating for residential care

A person's urgency rating is different to their need for residential care.

When selecting Residential Permanent assessors will be required to give a response to ' What is the urgency of this care type.' This question is a mandatory question with a rating to be selected from high, medium or low.

The Rules specify when an urgency rating of low, medium or high will apply to an individual in relation the classification type ongoing for residential care. The table below summarises the criteria for each urgency rating.

Table 50. criteria for urgency ratings for residential care

Urgency rating	Description
High urgency	**This rating applies if:** • The individual has a need for immediate access to ongoing funded aged care services delivered in an approved residential care home which, if not met, may place the individual's safety, health or wellbeing at risk.

FOI 27-3598 - Document 3

Urgency rating	Description
	Indicators: Recent falls, hospital admission, unsafe to return home, severe decline. **Example**: A client in hospital post-fall who lives alone and whose needs exceed Home Care supports.
Medium urgency	**This rating applies if:** • The circumstances for a high urgency rating do not apply to the individual; and • When considering the individual's circumstances and preferences, the individual is expected to seek access to permanent residential care within the next 6 months. **Indicators**: Declining function, rising carer stress, complex but not urgent risks. **Example**: A client with moderate incontinence and cognition issues whose carer is overwhelmed.
Low urgency	**This rating applies if**: • The circumstances for a high or medium urgency rating do not apply to the individual. **Indicators**: Some decline, minor falls, current supports are working, client prefers to delay move. **Example**: A client managing at home with informal support but thinking about future needs.

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Note: The urgency rating reflects how soon an individual needs residential care to avoid significant risk to their health or safety. This is separate from whether they *require residential care* or have *high-level care needs*—it's about the *timing* of that need.

Assessors are expected to select the rating which balances objective consideration of needs with the subjective perspective of the older person and/or appointed decision maker/s. Assessors should include a brief note in the *reason or comments* section explaining key reasons for the rating. See Chapter 6 for more information.

FOI 27-3598 - Document 3

8.7. Approving residential respite care

8.7.1. Step 1. Decide if the older person requires short-term residential care

Like permanent (ongoing) residential care, residential respite is delivered through the service group residential care. Access to residential respite requires an access approval for the short-term classification type. It is provided by registered providers in approved residential care homes.

Before approving a recommendation for residential care, assessment delegates first need to decide if an older person requires and is eligible to access this service group.

There is one key point to remember when deciding on access for older non-Aboriginal or Torres Strait Islander people. **Section 68** of the *Aged Care Act 2024* (the Act) requires these older people to have a continuing need for funded aged care services (including nursing) because of sickness in order to access the residential care service group. This requirement is also applicable to time-limited approvals including residential respite care. As an Assessment Delegate approving an individual for residential respite care assessment, they need to be satisfied that an older person's sickness at the time of the assessment means they have a continuing need for residential care including nursing services for a limited period of time.

Residential respite care is provided on a temporary basis within an approved residential care home. It is intended to give either the individual or their carer a short-term break from ongoing care responsibilities. Residential respite should only be recommended and accessed when there is a genuine short-term requirement for care. It is important to note that residential respite care is not a substitute for aged care rehabilitation or restorative care services.

Individuals approved for residential respite care are entitled to up to 63 days per financial year, with a possible 21-day extension under the *Aged Care Rules 2025*. These respite days do not need to be taken all at once and can be used flexibly throughout the year. Note that these timeframes do not apply where services are accessed under a specialist aged care program.

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8.7.2. Step 2. Decide the classification level

When recommending an individual for residential respite care, assessors should complete the De Morton Mobility Index - modified (DEMMI-modified) assessment. This tool assesses the individual's mobility and determines their eligibility for one of three respite funding classes: Respite class 1, Respite class 2, Respite class 3, based on the level of mobility observed.

The DEMMI-modified assessment is available within the IAT but can only be used as part of a Comprehensive Assessment, as it must be completed by a clinically trained assessor that has completed the DEMMI-modified training.

It is a Clinical Assessment Delegate's responsibility to ensure that the DEMMI-modified has been accurately completed.

FOI 27-3598 - Document 3

If the DEMMI-modified assessment cannot be completed at the time of assessment, the individual will be temporarily assigned a default funding class (Class 0). This classification remains in place until a formal Residential Aged Care funding assessment is carried out within the residential aged care home, at which point the appropriate funding class can be determined based on the individual's assessed mobility.

8.7.3. Extensions for residential respite

Assessment Delegates may receive requests for a 21-day extension to residential respite care – for example, when a carer is unwell or temporarily unable to resume their care responsibilities. There is no limit to the number of extensions that may be granted beyond the standard 63 days of respite care per financial year.

Typically, the residential aged care provider submits the extension request via the My Aged Care Service and Support Portal, and an assessment organisation receives it through the Assessor Portal for an Assessment Delegate's action.

It is the responsibility of the assessment delegate to review the request and either approve or decline it. Once a decision is made, the Assessment Delegate must communicate the outcome to the provider.

An assessment delegate will need to be satisfied that an increase in the number of respite days was necessary due to any of the following:

(a) carer stress

(b) severity of the individual's condition

(c) absence of the individual's carer

(d) any other relevant matter (for example, where a provider delivers an episode of respite care in good faith but subsequently finds out the care recipient's allocation of respite days had already been exhausted).

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Please note, there is no right of review if an extension request is declined.

Once decided, you must give written notice to the registered provider of your decision whether to extend within 28 days after the application was made. This written notice must include the day the decision takes effect, which may be before the day the decision is made.

Extensions are granted only at the previously approved level of care. If a higher level is needed, a reassessment and new approval by you (or another Clinical Assessment Delegate) is required before the extension can be granted



Managing residential respite care | Australian Government Department of Health, Disability and Ageing

FOI 27-3598 - Document 3

8.8. Approving transition care

8.8.1. Step 1. Decide if the older person requires transition care

Available following a hospital admission, transition care is delivered under the service groups of home support, assistive technology and residential care.

The Transition Care Program (TCP) is designed to support individuals in the period immediately after discharge from hospital. It aims to facilitate recovery, improve functional capacity, and provide time and support in a non-hospital environment while long-term care arrangements are being considered. The 'non-hospital environment' may be a home or community setting, or a residential care home.

Transition care and the Aged Care Act 2024

Before approving a recommendation for transition care, Assessment Delegates first need to decide if an older person requires and is eligible to access one of the relevant service groups.

Please note section 68 of the *Aged Care Act 2024* (the Act) (relating to 'people who are sick') applies to approving transition care in the same way it applies to approving residential respite care. Section 67 of the Act (relating to people who have a disability) also applies to approving people for transition care in the same way as it applies to approving people for home support (under the Support at Home program or CHSP) and assistive technology (under the AT-HM scheme or CHSP).

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To access hospital transition care, an individual must first undergo an aged care needs assessment following a hospital admission. If it is decided they require and are eligible for hospital transition care, under the Act Assessment Delegates must approve them for:

- the classification type hospital transition for all three of the following service groups: home support, assistive technology and residential care
- the service type assistance with transition care under the home support service group
- all service types that can be delivered through the Transition Care Program, as specified in sections 50, 53 and 62 of the *Aged Care Rules 2025*
- the corresponding classification level for each of the service groups approved: *HS HT class* for home support, *AT HT class* for assistive technology and RC HT class for residential care.

If the support plan includes a recommendation for TCP, the Notice of Decision template the assessment delegate generates in the Assessor Portal will include wording covering all the required approvals listed above. The table below summarises the service group, classification type and classification level approvals given whenever an older person is approved for transition care through TCP.

FOI 27-3598 - Document 3

Table 51. Summary of approvals under the Act for hospital transition care

Service group	Classification type	Classification level
Home Support	**Hospital transition**	HS HT class
Assistive technology	**Hospital transition**	AT HT class
Residential Care	**Hospital transition**	RC HT class

Access to transition care

Transition care is time-limited, with individuals allocated a funded period of 12 weeks to access services under the program. However, if the individual's recovery requires additional time, the service provider can apply for an extension.

The Transition Care Program is defined under the *Aged Care Act 2024* as a specialist aged care program. The number of places available for this care type is determined by the Minister, based on state and territory needs. Only registered providers are permitted to deliver hospital transition care using these allocated places.

Importantly, to be eligible for the program, the individual must be:

- medically stable at the time of assessment; and
- is in the concluding stage of a hospital episode; and
- has the potential to benefit from accessing services delivered through the relevant service group under the TCP; and
- at the time the assessment was carried out, a hospital inpatient.

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It is an assessment delegate's responsibility to confirm medical stability before approving access to the program.

Once an individual is approved for hospital transition care, it is usual practice for hospital discharge staff to refer them directly to their local Transition Care provider, following delegated approval.

Accessing residential care/residential respite and transition care

A person in permanent residential care who is receiving Transition Care must take Hospital Transition Leave for the duration of their TCP episode. In addition, they are not eligible to receive services under the Restorative Care Pathway under Support at Home.

An individual receiving Transition Care is unable to access residential respite care while Transition Care is in effect.

Duration of Transition Care

The standard period for a transition care episode is 12 weeks (84 days).

This period may be extended by 6 weeks, so the total transition care episode is 18 weeks (126 days) if the individual makes an application in accordance with the requirements of the Rules and is determined to require access to the services for the additional period.



Transition Care Program Guidelines | Australian Government Department of Health and Aged Care

8.8.2. Step 2. Record the decisions

When recording a decision to approve an individual for transition care, Assessment Delegates will be required to confirm a priority level for the care type. For transition care approvals, assessment delegates must ensure a priority level of 'high' is assigned to all approvals. This is a system requirement. Older people will continue to be able to access TCP services immediately and the priority category for TCP will appear in the NoD as n/a.

8.9. Other approvals and considerations

8.9.1. Alternative entry – giving approval after service commencement

Care, including urgent care, can be approved when assessment wasn't possible prior to accessing those services. Section 71 outlines that an individual can be approved for services even if an assessment was unable to be conducted prior to accessing those services if the individual applies within the specified period under the *Aged Care Act 2024* (the Act) and the System Governor is satisfied that certain circumstances applied to the individual. Further information around this is detailed in Chapter 3: Referral, registration and screening.

If an assessment delegate is satisfied one of the alternative entry circumstances applies to an individual and that the other requirements under section 71 have been met, the Act allows the date of effect of approval to be set to the date care began. The Notice of Decision (approval letter) template includes wording to cover this scenario, to ensure that providers are paid from the beginning of service delivery. Delegates prompted by the system to enter a 'Delegation date' for their approval should always enter the actual day they make the decision, not the day when care began.

In most cases, individuals who have accessed a service prior to an assessment would have accessed this service through the My Aged Care contact centre urgent services pathway. Other circumstances may be emergency respite care and services provided by National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) and Multi-Purpose Services Program (MPSP).

Services delivered before an assessment may not always be visible in the Notice of Decision (approval letter). Assessment delegates should always check the Support Plan in the Assessor Portal to view these services and be sure that they consider whether or not to approve these services.

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Application process for people who have received aged care services and have not yet applied for an assessment under My Aged Care

NATSIFCAP and MPSP

Alternative entry pathways are available for individuals who commenced accessing specialist aged care services such as NATSIFACP and MPSP before an approval was given and at the time they were seeking access to services there was a significant delay in the availability of an approved needs assessor to conduct an assessment.

An application can be lodged for access to Commonwealth subsidised services under the Act's alternative entry provisions via any of the available application pathways (e.g. My Aged Care Contact Centre, Aged Care Specialist Officers online referral or self-referral through an Assessment Organisation). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 30 days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

Residential care or residential respite care

Alternative entry pathways are available for individuals who require urgent residential care or residential respite care. To be eligible, at the time they accessed this care, there must have been a significant risk of harm to the individual if those services were not delivered before approval to access funded aged care services was given.

An application can be lodged for access to residential care or residential respite care under the Act's alternative entry provisions via any of the available application pathways (e.g. Contact Centre, online referral or self-referral through an Assessment Organisation) or by submitting the *Emergency Residential Care - Application for Care* form (see below). The service provider may help the client with completing/submitting the application. Unless an extension is granted by the System Governor, applications must be lodged within 5 days after the first day of care commencing. The application should include the date the individual began receiving care, ensuring appropriate alternate access dates are approved.

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If completing the *Emergency Residential Care - Application for Care* form, the form must:

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

If an older person and/or their active, active, appointed decision maker recognised under section 28 of the Act is unavailable, the registered provider may sign the form.

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

If a provider prefers the older person's appointed decision maker to sign the form, they may apply for an extension. Under section 71 of the Act, an extension must be requested if the application cannot be submitted within the required timeframe.

Intake and assessment process for an Emergency Residential Care – Application for Care

When the form is received, the assessment organisation must:

- Ensure the form is signed by the older person, or their active, appointed decision maker recognised under the Act, and confirm the *emergency case* section is completed correctly by the registered provider.
- Confirm the date the form was received. If it was submitted after 5 calendar days from the care start date, assessment can only proceed if the provider has been granted an extension by the System Governor, following an application for extension.
- Register and self-refer the older person in the My Aged Care Assessor Portal (if required and self-referral criteria are met).
- Assign intake priority. Although the person is already in care, the triage delegate must consider the urgency of the individual's circumstances. If the person's condition is rapidly deteriorating, the assessment should be scheduled as soon as possible.
- Upload the verified form to the older person's record.
- Schedule a comprehensive assessment with an assessor. Where possible, this should be face-to-face and collect information to:
  - Determine the older person's required level of care; and
  - Confirm that urgent circumstances existed at entry and that prior approval was not practicable.
- Record the Emergency Care start date (for residential care or residential respite) before sending to the assessment delegate.
- The assessor must collect as much information as possible about the urgent situation from the older person, their registered supporters (if available, and in line with the older person's will and preferences), their active, appointed decision maker/s (as relevant), the registered provider, and any other professionals involved at the time of entry.

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Making a decision about alternative entry

Assessment delegates are responsible for determining whether an older person who commenced care before applying for approval can be approved under alternative entry. To do this, they must ensure that the application process meets all relevant requirements described in this content, including, that the older person is eligible for the type of care being provided, and that the care was urgently needed at the time it began. Assessment delegates must also be satisfied that it was not practicable to obtain approval before the care commenced (see circumstances described above). The decision must be based primarily on the care needs of the older person at the time they entered care.

If care is approved under urgent circumstances, an assessor will need to update the My Aged Care assessor portal. This includes checking the *Emergency Care* flag and recording the date the older person entered care. Doing so ensures the registered provider receives the appropriate Commonwealth subsidy from the correct start date. An assessor will also send the referral to the provider via the portal, allowing them to access the older person's record and view all relevant approval details.

Assessment delegates should also be aware that this process applies in cases where the assessment has been completed but the older person passes away before a decision is made.

Not all circumstances qualify as urgent. Situations such as a bed becoming available in a residential aged care facility, or a transfer from an acute care setting to another care environment, do not meet the criteria for urgent admission.

FOI 27-3598 - Document 3

If an assessment delegate determines that the older person did not urgently require care at the time of entry, but they are otherwise eligible, the application can still be approved, however the date of effect will be the date you make the decision.

The decision about whether to approve alternative entry dates for an older person is a **reviewable decision** under section 557 of the *Aged Care Act 2024.*

Assessment delegates are required to record their justification for approving under alternative entry so that there is clear evidence of a person meeting one of the requirements under section 71.

Extensions

While it is best practice for providers to submit the *Emergency Residential Care - Application for Care* form–complete with the emergency case section–within the required timeframes of the older person entering care, the *Aged Care Act 2024* allows an application for an extension of time under section 71 if this is not possible.

If the form is not signed and submitted within the required five-day timeframe, it is considered incomplete. In this case, the registered provider must first apply to the System Governor for an extension The delegation for granting extensions for those seeking access to funded aged care services through alternative entry will sit outside Assessment Organisations.

In considering an extension the System Governor will either decide to:

- Approve the application and determine a longer period for the individual, or
- Reject the application

As soon as practicable after a decision has been made, the System Governor must provide notice of their decision. Included in the notice will be the reasons for the decision and how to apply for a reconsideration of the decision.

Where the older person has not made their application in the required timeframe, an extension may be granted by the department. In these instances, please email a request for an extension to AssessorSupport@health.gov.au. Please include a brief explanation on the reason for the extension.

If an assessor believes the older person urgently needed care but the approval is already recorded in My Aged Care with a later date, they must initiate the **corrections process** to backdate the approval. If the required backdating exceeds **42 days**, a correction cannot be made, and a reassessment is required.

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8.9.2. Exceptional circumstances – approving a service without an assessment

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

In a case where the older person has passed away, assessors should follow the *Client Deceased Before Assessment* process available through the My Aged Care assessor portal.

FOI 27-3598 - Document 3

This ensures the approval is properly recorded in the system and automatically submitted to **Services Australia**.

If there are complications preventing the use of the online process, an assessor should consult their Team Leader for advice. Do not cancel the assessment in My Aged Care using the reason 'client deceased.' This action changes the older person's status to 'deceased' and locks the record as read-only, preventing an assessment delegate from recording an assessment decision.

If the record has already been locked, the assessor must contact the My Aged Care Service Provider and Assessor Helpline (1800 836 799) to temporarily reactivate the record so the assessment outcome can be recorded. Once the decision is entered, the status must then be changed back to 'deceased' to reflect the older person's passing.

Client is receiving services but is refusing an assessment

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

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FOI 27-3598 - Document 3

9. Chapter 9: Finalising the assessment and service referral

What you'll find in this chapter

This chapter includes guidance about:

- finalising the assessment
- recording and communicating the assessment outcome
- referring the older person for services, and supporting them to access services
- the single provider model for Support at Home (which includes a single referral code for all services/pathways)
- completing the Notice of Decision (approval/non-approval letter).

9.1. Overview of assessment finalisation

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An assessment is finalised when:

- the assessment and support plan are completed; and
- all required decisions have been made and recorded by the Assessment Delegate; and
- when effective referrals have been made or the older person has decided not to proceed with accessing aged care services, and
- the older person (and their registered supporter/s and/or appointed decision maker/s, if applicable) has been notified of the assessment outcome.

An effective referral is where:

- a referral is accepted by a service provider who can deliver a service response consistent with the relevant service recommendations on the older person's Support Plan, **or**
- the older person has accepted responsibility for managing their own referral(s) through a referral code, **or**
- the outcome of the assessment is that no further action is required by the assessor; **or**
- the assessor has made all available and reasonable efforts to connect the older person with a service provider appropriate to their assessed care needs.

For older Aboriginal and Torres Strait Islander people, FNAO assessors may facilitate the client's entry into aged care or refer the client to an Elder Care Support worker to assist the client to connect with services after the assessment is finalised.

When the Support Plan is finalised and an effective referral has been made, the assessor should inform the older person to contact their provider, ECS worker or the My Aged Care contact centre if there is a future change in needs, goals, or preferences. If within their remit, the My Aged Care contact centre will assist the older person with their enquiry. This could include re-issuing a referral code or if a referral is rejected, sending a referral to another provider. The contact centre or the provider can send a support plan review request to the assessment organisation if it is an appropriate request.

Where appropriate, assessors are encouraged to follow up vulnerable or at-risk older people post-assessment who:

- have referrals that have been rejected/not actioned - this may include the monitoring of referrals to services or negotiating with service providers for the provision of alternative services if necessary,
- are working on short-term reablement goal(s) – in line with the length of time stipulated in the Support Plan, and/or
- are vulnerable older people, as determined by complexity indicators or need for linking support and required short-term linking assistance purpose of implementing the Support Plan.

After finalising the assessment, where the department becomes aware that an older person is having difficulty with accessing services, an assessment organisation may be required to follow up with the older person or service provider and provide advice on any follow-up action/s taken.

9.2. Setting the access approval date of effect ('delegation date')

For an older person's application, the access approval date of effect that Assessment Delegates decide applies to all of the following decisions under section 65 of the *Aged Care Act 2024* (the Act):

- the service groups, and the classification types for those service groups
- the service types (and services if applicable).

Assessment Delegates record this date in the Assessor Portal after giving responses to all of the care recommendations. In the 'Save decision and delegate' popup, the Delegate should enter the day that they are making the decision (that is, that day's date) and click 'Save decision.' Note that even if the older person has received services before assessment (using the alternative entry provisions under Section 71 of the Act), the Assessment Delegate should still enter the date the decision is made - not an earlier date.

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There is wording in the Notice of Decision (approval letter) relating to alternative entry scenarios and the access approval date of effect.

For emergency residential care or residential respite, the assessor is required to record the date care began through the "Emergency Care Start Date" flag in the Integrated Assessment Tool. This date will allow the service provider to claim for the days prior to the delegation start date. The Assessment Delegate should check this to ensure that the correct date is recorded in this field before proceeding with their decision.

9.3. Recording and communicating the assessment outcome

A critical record of the assessment outcome is the Notice of Decision (NoD). Note that the NoD is referred to as the 'assessment outcome letter' in materials and website content for older people and is labelled as the 'approval/non-approval letter' in the assessor portal.

FOI 27-3598 - Document 3

The older person (and registered supporter/s and/or appointed decision maker/s, if applicable) should be sent the following documents:

- the NoD
- the finalised Support Plan
- the referral code letter (at a minimum for older people who have been approved for CHSP services)
- NoD attachments for NoD Approval letters with a home support outcome
- any relevant aged care consumer information not provided at the time of the assessment
- the older person satisfaction survey of the organisation's performance requirements
- other associated notification documents.

The assessor must:

- call the older person once the NoD is finalised to notify them that their assessment has been completed (where needed, FNAO assessors may also explain the letter to the older Aboriginal and Torres Strait Islander client)
- advise the older person that their Support Plan and NoD can be accessed via their My Aged Care Online Account (under 'documents' and 'plans' for the Support Plan) and their My Health Record (if the older person has consented)
- advise the client that if they have provided consent, their registered supporter/s are able to access these documents (via their own separate login information) to the client portal
- advise the initial referral source of the assessment outcome and referral outcome - if requested by the referrer and with the consent of the older person.

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While it is considered good practice to offer an older person a hard copy of their Support Plan and relevant information, where this is not feasible for an assessment organisation, the minimum requirement is that the older person, and where relevant, registered supporter:

- is clear on what is in their finalised Support Plan and are agreeable to this and which associated people it will be shared with,
- agrees to be provided a soft copy of the finalised Support Plan and if appropriate the referral code letter (noting that older people will receive a letter once they have been assigned a package), and/or
- is aware of how to obtain a copy of the Support Plan and relevant information via their My Aged Care Online Account.

9.3.1. Notice of Decision of assessment outcome

Assessment Delegates are required under the *Aged Care Act 2024* (the Act) to issue a Notice of Decision (NoD) to the individual within 14 days of making a decision under subsection 65(1) or (2).

This supports the Act's rights-based approach by promoting transparency, accountability, and informed decision-making, and by ensuring individuals understand decisions that affect their care and access to aged care services.

FOI 27-3598 - Document 3

The NoD must clearly communicate:

- the assessment outcome, including decisions to approve or not to approve access to services,
- the reasons for these decisions, and
- how the individual may apply for a review of the decision(s).

NoD requirements under the Act

For assessment delegates to meet their obligations under the Act, they must ensure that the notice sent to the individual satisfies the requirements of the Act. Assessment delegates can generate NoD templates in the Assessor Portal with most of the critical information pre-populated and which also includes guidance on how to complete a legally compliant letter. The NoDs must satisfy the requirements in the following sections of the Act:

- **Section 70:** notify the individual about the decision regarding their access approval, including information on the approved service group(s), and the classification type(s) for the service group(s), any service types, and funded aged care services, and the date the access approval takes effect. The reasoning behind the decision and how the older person can apply for a review of decision, if necessary, must also be clearly explained. The 'About the decisions: Reasons and Review Options' section in the NoD gives more information on what must be considered and included in the reasons.
- **Section 79**: inform the individual about the classification decision, including the classification level(s) for the approved service group(s), and when the classification level(s) did or will come into effect, and how they can apply for reconsideration if necessary.
- **Section 88:** If necessary, notify the individual about any priority category assigned to a classification type for a service group, clearly explaining the reasoning behind the decision and how they can apply for reconsideration if necessary. This is necessary in the scenarios listed in the table below.

Service group	**Classification type**
Home support	Ongoing (except when the classification level is 'CHSP class')
Assistive technology	Ongoing Short-term
Home modifications	Short-term
Residential care	Ongoing

- **Section 92(4):** If necessary, inform the individual of any place they have been allocated, and the day the allocation of the place takes effect.

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