



Australian Government  
Department of Health



**myagedcare**

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# MY AGED CARE ASSESSMENT MANUAL

For Regional Assessment Services and Aged Care Assessment Teams

Version 1.1 June 2018

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## PART A - INTRODUCTION

### 1. Overview

The My Aged Care Assessment Manual (the Manual) is designed to drive good practices in the assessment of older people's support needs and eligibility for Commonwealth subsidised aged care services under the Commonwealth Home Support Programme (CHSP) and/or types of care under the *Aged Care Act 1997* (the Act). The Manual integrates and updates the Regional Assessment Service (RAS) Guidelines June 2015, the Aged Care Assessment Program (ACAP) Guidelines May 2015 and the Good Practice Guide for Consistent Assessment August 2017.

The Department intends to regularly review and update the Manual as required to ensure it remains up-to-date in the context of future system changes and enhancements to the My Aged Care operating model. Assessment organisations are welcome to provide feedback to the Department of Health (the Department) at any time including suggestions on how the Manual can continue to be improved to drive good assessment practice and support quality outcomes for aged care consumers.

In addition to the Manual, assessors should also view the following resources:

- [Aged Care Assessment Workforce - My Aged Care system and process overview](#)
- My Aged Care assessor guidance material available on the Department [website](#)
- My Aged Care assessor training materials
- Aged Care Assessment Supplementary Guidelines for Younger People with Disabilities.

To keep the Manual concise, text boxes with links to further information appear throughout the document. The document is also designed to be accessible for people using assistive technology.

### 2. My Aged Care

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

The key elements of My Aged Care include:

- A National Contact Centre (the contact centre) with a single national phone number for consumers, their representatives and carers
- The My Aged Care website providing easily identified points of entry for consumers and clients of aged care services
- An assessment capability to identify client needs using the National Screening and Assessment Form (NSAF)

- A central client record that will include each client's current aged care requirements and associated history and services provided through My Aged Care
- A match and refer capability that enables the contact centre and assessors to find appropriate assessment, home support, residential and community support services or resources for clients
- Web-based portals for clients, assessors and service providers.

An assessor can use My Aged Care to:

- Manage their assessment organisation contact details and set up of individual staff members
- Manage referrals for assessment
- Conduct assessments using the NSAF and develop the support plan
- Make delegate approvals (for Aged Care Assessment Team [ACAT] delegates)
- Conduct support plan reviews
- Refer clients for service
- Review and update client records consistent with the assessment and support plan outcomes.

### 3. Programs

#### 3.1. Regional Assessment Services (RAS)

The Commonwealth directly engages 14 RAS organisations to operate the RAS in Aged Care Planning Regions across Australia. Western Australia will commence My Aged Care RAS operations in July 2018. These organisations are responsible for the provision of Home Support Assessment services in those jurisdictions including the assessment of service eligibility for the CHSP. The RAS may deliver Home Support Assessments through subcontracting arrangements subject to approval from the Department.

The RAS is designed to give a clear access pathway and greater choice of entry level services to older Australians who wish to continue living at home and can do so with some support. RAS assess client needs, goals and preferences holistically and refer them to services that will help them achieve the best possible level of function and independence.

The RAS deliver the assessment of client needs independent of provider preferences and ensure clients are referred only to the services that will fulfil their needs and goals.

#### 3.2. Aged Care Assessment Program (ACAP)

The Commonwealth Government funds the States and Territories to administer the Aged Care Assessment Program. Assessments under this program are conducted by the Aged Care Assessment Teams (ACATs). State and territory governments are responsible for the day-to-day operation of the ACAP including the timely delivery of assessments for care types under the *Act* as well as the management, training and



performance of individual ACAT assessors. Each jurisdiction is required to manage workloads to ensure that priority is given to those in greatest need and that access to aged care services is not delayed unnecessarily.

Each ACAT is multi-disciplinary and includes a range of health-related disciplines such as medical practitioner, registered nursing, social work, physiotherapy, occupational therapy and psychology. The Department has oversight responsibility for the ACAP including providing advice on Australian Government policy, the monitoring and reporting of performance against agreed service levels, and the management of regulatory and other administrative processes relating to the *Act*. The Department and the state and territory governments are jointly responsible for establishing communication protocols, working cooperatively to develop nationally consistent approaches to ACAP operations, and participating in regular forums to support the national administration of the ACAP.

### 3.3. Aims

The RAS and ACAP aim to:

- Deliver timely, nationally consistent assessments of a high quality
- Ensure that older people from special needs groups have equitable access to assessment services
- Ensure that assessments of older people are holistic, incorporating physical, medical, psychological, cultural, social, environmental and wellness dimensions
- Involve clients and their carers, representatives and other service providers (where appropriate) in assessment and care planning processes
- Deliver tailored support plans that improve the health and wellbeing of older people, are based on a client's goals and current care needs and consider wellness and reablement approaches
- Facilitate access to the combination of Commonwealth subsidised and non-subsidised aged care services that best meet the assessed needs
- Assist clients to remain in the setting most appropriate to their needs and that prevents premature or inappropriate admission to residential care
- Provide short-term linking assistance or care coordination to vulnerable clients to address barriers that affect their access to aged care services.

Further information:

The My Aged Care [website](#)

The Department of Health [website](#) My Aged Care

## 4. Types of Assessment

### 4.1. Home Support Assessment (usually by a RAS)

A Home Support Assessment builds on the information collected in contact centre registration and screening, with a further level of detail to determine a client's eligibility to receive CHSP services. Home Support Assessments are generally conducted face-to-face in the client's usual accommodation setting.

Home Support Assessments involve collecting information on the client's:

- family, community engagement and support
- health and lifestyle
- level of function
- cognitive capacity
- psychosocial circumstances
- home and personal safety
- level of complexity and risk of vulnerability
- goals, motivations and preferences.

During the assessment, the assessor and client will work together to establish a support plan that reflects the client's strengths and abilities, areas of difficulty, and the support that will best meet their needs and goals. This will include the consideration of formal and informal services as well as reablement pathways where appropriate.

### 4.2. Comprehensive Assessment (ACAT only)

A Comprehensive Assessment, undertaken by the ACATs, builds on the information collected in the contact centre screening and Home Support Assessment (if applicable) and in a suitable face-to-face context (preferably in the client's usual accommodation setting) to determine a client's eligibility for care types under the *Act*.

The Comprehensive Assessment encompasses the same client information as the Home Support Assessment at a deeper level. The assessor will comprehensively assess the client's physical capability, medical condition, psychosocial factors, cognitive and behavioral factors, physical environmental factors and restorative needs. The assessor and client will work together to establish a support plan that reflects the client's strengths and abilities, areas of difficulty, and the support that will best meet their needs and goals. This will include the consideration of formal and informal services as well as reablement and/or restorative pathways.

Where a care type under the *Act* is identified as the most appropriate type of support to meet the client's needs, and the client meets the eligibility criteria, the assessor will make a recommendation for approval. A client may be approved for a Home Care Package, Residential Care, Residential Respite Care or Flexible Care (Transition Care Program [TCP] or Short-Term Restorative Care [STRC]). Clients may also be referred to CHSP services where appropriate.

## 5. Privacy and Consent

### 5.1. Privacy Legislation

Assessors are required to comply with the legislative requirements under the *Privacy Act 1988* (the *Privacy Act*), including the Australian Privacy Principles (APP).

The *Privacy Act* applies to the collection, retention and use of personal information by assessors and regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information.

The *Privacy Act* includes 13 APPs that apply to the handling of personal information by most Australian and Norfolk Island Government agencies and some private sector organisations. Both use and disclosure of personal information is covered by APP 6 of the *Privacy Act*.

The collection of personal and sensitive information is regulated by Australian Privacy Principle (APP) 3 of the *Privacy Act*. The collection of sensitive information (defined by the *Privacy Act* to include health information) is regulated by clause 3.3, and is more rigorous than the requirements relating to personal information that is not also sensitive information. Assessors will invariably collect persons' sensitive information as part of the assessment process.

Clause 3.3 of APP 3 provides that sensitive information can only be collected by an agency where the information is reasonable, necessary or directly relates to the agencies functions and with a person's consent, subject to the exceptions such as if 'required or authorised by or under an Australian law'.

Penalties may apply to organisations and individuals for breaches to the *Privacy Act*.

For ACATs, assessment information collected for purposes of the assessment is 'protected information' under Division 86 of the *Act*. It is an offence to disclose protected information except in circumstances specified by the *Act*. The maximum penalty for this offence is imprisonment for two years. However, section 86-4 of the *Act* allows persons conducting assessments to disclose, record or use protected information in specific circumstances, with all reasonable steps taken to protect client information. See more information on the assessors' responsibilities around the protection, use and release of personal information at 23 Record Keeping of Information.

### 5.2. Representatives

A representative for someone in My Aged Care is able to speak and act for the client.

A representative can:

- provide information to My Aged Care about the client including talking to assessors, the contact centre and service providers

- make decisions about aged care assessment and referrals for aged care services
- see and update client information through the contact centre or on the My Aged Care client record accessed through the myGov website
- be listed as the client's primary contact so they can be the first contact point for My Aged Care.

### *Regular representative*

If the client is able to provide consent for someone else to speak and act on their behalf, they may nominate a regular representative. The client may also nominate the regular representative as the primary contact so they are the first point of contact for My Aged Care. However a regular representative will not receive written correspondence.

The client can choose any individual to become a regular representative. This could be a family member, friend or someone who works for a service provider.

My Aged Care creates a record for all representatives. This is used to authenticate a representative, and ensure that My Aged Care is speaking to the right person. To create a record, My Aged Care captures personal information, which may include the representative's Medicare card number and date of birth.

### *Authorised representative*

An authorised representative is needed if the client is not capable of providing consent for someone else to speak on their behalf. Legal documents are required to be in place for an authorised representative so that My Aged Care knows they can legally represent the client. The documents required depend on the rules in each state or territory. The Appointment of Representative form and other accepted legal documents are available as attachment types in the assessor portal. An authorised representative is the primary contact for all communication with My Aged Care, and will receive all correspondence.

## 5.3. Consent

Assessors must obtain consent, written or verbal, from the client prior to undertaking an assessment. If the client is not able to give consent, the consent should be obtained from a person who has the role of a regular or authorised representative in My Aged Care. Where there is no representative to assist with consent, the person will need to be referred to an organisation in their state or territory that is responsible for appointing a guardian.

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

- The assessor should ensure the client understands the purpose for collecting the information and how it will be used and stored, and who the personal or sensitive

information will be collected from (such as contacting a person's GP, other health professionals, family members or carers)

- The client must be able to make an informed decision about whether they want personal information disclosed to others. When the client consents to an assessment, they are made aware that they are agreeing to their information being collected for the purposes of the assessment and where appropriate with other parties for the purposes of providing aged care or other community, health or social services to the person
- A client's right to confidentiality must always be respected. If an Assessor considers that maintaining confidentiality will interfere with or compromise their role in relation to a client, the matter should be discussed with the client or their authorised representative
- When sharing client information with other parties, assessors should ensure the information is shared securely and is received by individuals who are authorised to receive the information and on a 'need to know' basis
- Ensuring that other parties who receive client information are aware of privacy requirements and have procedures in place to ensure that the client's information is not misused
- The assessor must record the consent (and any circumstances of any disclosure of a client's personal information) as 'Notes' in the My Aged Care client record. If there is a formal consent or disclosure form completed then it is uploaded in the client record through the 'Attachments' function
- Clients are aware that once consent for assessment is gained for the use and disclosure of personal information as authorised by the *Act* and when the Application for Care approval is finalised, that records need to be retained in accordance with the *Archives Act 1983*.

The Office of the Australian Information Commissioner (OAIC) website has resources that assist in the process of ensuring compliance with the *Privacy Act*.

Further information:

The Healthdirect [website](#) for the Healthdirect Privacy Policy

The Office of the Australian Information Commissioner [website](#) and the [Privacy fact sheet 17: Australian Privacy Principles](#)

The Federal Register of Legislation website for the [Aged Care Act 1997](#) Division 86 part 6.2 Protection of Information

The My Aged Care website for the [Assessor representation changes](#)

## PART B – SCREENING, REFERRALS & ASSESSMENT

### 6. Key Features Assessment

The key features of a My Aged Care assessment include:

- an independent, holistic, timely, client-focused assessment of individual client aged care needs that is separate from service provision
- face-to-face assessments as best practice and whenever possible
- involvement by family and their carers, representatives or other advocates as appropriate
- a focus on assessing current needs of the client, and not recommending services that are not supported by the assessment
- embedding wellness and reablement approaches where appropriate
- supporting client choice and incorporating goal-based support planning
- consideration of both formal and informal services to support clients to live independently in their own home
- building and maintaining effective and respectful working relationships with all My Aged Care assessors and service providers
- extending connections with services and organisations in local communities including those not listed on My Aged Care
- identifying clients with special needs and vulnerable clients who require short-term case management (i.e. linking support) or care coordination
- awareness of cultural and/or religious values, beliefs, gender identity or sexual preferences
- supporting the My Aged Care system to prevent duplication and provide capacity to pre-populate and re-use information from one level of assessment to the next
- a multi-disciplinary approach (ACATs only).

In addition to the principles, assessors should promote the client's right to:

- be treated with dignity and respect
- receive information about the assessment process, to be told what is happening and why and to give their consent
- talk about their own views and ideas
- have their personal information treated in confidence
- have someone with them during the assessment if they wish
- have an interpreter or other communication support to assist with the assessment
- talk to an independent advocate who can help them with advice
- be able to make a complaint or request a review of an assessment outcome.

## 7. National Screening and Assessment Form (NSAF)

The national screening and assessment process, facilitated through using the NSAF, has three components:

- Screening over-the-phone by the My Aged Care contact centre
- Home Support assessment conducted face-to-face by the RAS
- Comprehensive Assessment conducted face-to-face by ACATs.

The NSAF has been designed to support skilled assessors to determine a client's aged care needs. Its development was based on best practice assessment processes from around Australia and through significant consultation with stakeholders.

The NSAF includes the questions to be asked as part of Screening, Home Support Assessment and Comprehensive Assessment. Information recorded on the NSAF flows from one level of assessment to the next. It ensures that questions are appropriate to each level of assessment; minimises the need for clients to retell their stories; and that the appropriate client pathway can be facilitated through the completion of an action plan or support plan. It also includes the assessment requirements for delegate approval for services under the *Act*.

### Decision support rules

The NSAF also includes a set of decision support rules that assists the RAS and ACATs to make recommendations for the type of support a client requires.

There are five types of decision support rules:

- pathway and eligibility (e.g. the client should be referred for Comprehensive Assessment)
- priority (e.g. access to assessment or service is a high priority)
- recommended actions (e.g. the client should visit a General Practitioner)
- complexity indicators (e.g. the client is living in inadequate housing or with insecure housing or is already homeless)
- needs identification (e.g. behavioural concerns).

It is important to note that the NSAF is neither a decision-making tool nor is it designed to recommend particular service types that a client should access. This is the role of a trained assessor who, when developing the support plan with a client, considers their needs holistically, and recommends support most appropriate to their needs and circumstances.

This may include referral to Commonwealth-funded services or provision of information about non-Commonwealth funded services that the client may wish to consider. Assessors must refer to the [NSAF User Guide](#) to ensure competency in the use of the NSAF and in the delivery of Home Support or Comprehensive Assessments.



## 8. Referral Process

### 8.1. Referral Pathways

The following referral principles guide the My Aged Care screening and assessment workforce in their decisions on client pathways. Nevertheless each client is an individual with unique circumstances that will also be taken into consideration.

#### Screening

Screening usually occurs after a person registers on My Aged Care, and has a client record created. Screening addresses a client's initial needs, circumstances and functional ability. The screening by the contact centre determines the assessment pathway – to Home Support or Comprehensive Assessment or referral to urgent services if required.

Where a client or their referrer requests an ACAT assessment, the appropriate referral pathway should still be supported by the outcome of the contact centre screening. The screening process and conversation with the client or referrer may confirm that the person is suitable for a RAS assessment. If the client is adamant they require an ACAT assessment, they should be referred for the ACAT assessment even if the screening outcome indicates a RAS pathway is appropriate. In this instance the contact centre will advise the client that the decision for approval of services will be determined by the ACAT and that the Comprehensive Assessment may still result in a recommendation for CHSP services.

For the assessment workforce, the principle is that clients with entry-level needs should be assessed by a RAS and those with more complex needs should be assessed by an ACAT. The assessment model has been developed so that an ACAT can match and refer to CHSP services (if appropriate) but a RAS cannot determine eligibility for services under the *Act*.

On entry to aged care, many clients will have chronic health conditions which are not in themselves trigger for a Comprehensive Assessment. For example, the client may have a cognitive condition or continence issue that is well managed and where a RAS assessment is the appropriate pathway.

#### Urgent referrals to home support services (time-limited)

A client may be referred directly to a service provider to receive time-limited support before receiving an assessment if the client has an immediate health or safety intervention that cannot be supported by other means.



In this situation the contact centre places a high priority on the referral to assessment organisation to ensure:

- that the services are in place and the urgent need is being addressed
- the assessment organisation provides a more thorough analysis of the needs and
- confirm or adjust the services as required.

Services under the CHSP that may be referred directly to a service provider are:

- nursing
- personal care
- meals and/or
- transport services (i.e. a one-off intervention such as transport to a GP appointment).

### [Web-form referrals](#)

Web-form referrals also contain decision support to guide the assessment pathway, however the incoming referrer is able to accept the recommended assessment pathway or recommend an alternative pathway. In this case the referrer is required to provide the reason for the recommended pathway.

### [Referrals between assessment organisations](#)

Following a Home Support assessment, an outcome may be that the client needs to be referred to an ACAT for a Comprehensive Assessment (with the client's consent) where it is identified the client has more complex needs that may better be met by services under the *Act*.

### [Self-referrals](#)

ACATs are able to self-refer clients to their organisation. This is required in instances such as when the ACAT is assessing one client and at the assessment the assessor identifies that the partner requires an assessment. Currently the RAS are unable to self-refer, but may facilitate a referral with the client's consent via the contact centre to issue a referral to their organisation.

In selected remote and very remote regions, identified RAS organisations have the ability to self-refer clients for an assessment, without the need to rely on the My Aged Care contact centre to issue the referrals. This functionality is being managed by the Department of Health.

### [Referrals for urgent service](#)

Clients who require additional or new services who have a previous assessment in My Aged Care will be referred to the assessment organisation that undertook the most recent assessment for review and to arrange these services. The contact centre is

unable to issue referrals for services that were not previously identified on the support plan.

## 8.2. Priority for Referrals

A referral for assessment will include a priority rating that relates to the timing of the assessment and the urgency in which services are delivered to a client. A priority category is also assigned when a client is referred to services. The allocation of a priority category for a referral is based on a client's level of function, the level of risk in relation to the care situation, and any other relevant concerns. The assessor is able to change a priority allocation that does not align with the guidance on priority for RAS and ACATs in Tables 1 and 2 below.

For web-form referrals, the priority is automatically set to medium.

The majority of support plan reviews are to be completed within 10 days noting that some review requests will be actioned more urgently than others. Where it is indicated on the referral that the review needs to happen within 10 days assessment organisations should prioritise these clients over others (see *10.6 Support Plan Review and New Assessment*). Many timeliness measures relate to Key Performance Indicators (KPIs) and other performance measures (see *27 Reporting and Performance*).

### RAS

Based upon the client's needs, there are three priority categories a RAS referral for assessment may be classified outlined in the table below. The RAS are expected to complete 90% of required actions within the timeframes outlined.

**Table 1 RAS priority categories**

Priority Level	Definition	Action referral	Complete
<b>High</b>	Requires an urgent assessment which if not met may place the client's health or safety at risk	3 calendar days	10 calendar days after acceptance
<b>Medium</b>	Not at immediate risk of harm but an assessment will be required in the short to medium term	3 calendar days	14 calendar days after acceptance
<b>Low</b>	Sufficient support available at present but the client requires an assessment in anticipation of their future care requirements	3 calendar days	21 calendar days after acceptance

## ACAT

Based upon the client's needs, there are three priority categories an ACAT referral for assessment may be classified. The ACAT are expected to complete 90% of required actions within the timeframes outlined below. In addition it is expected that 95% of ACAT assessments are completed within 75 days.

**Table 2 ACAT priority categories**

<b>Priority Level</b>	<b>Definition</b>	<b>Action referral</b>	<b>*To first clinical intervention</b>
<b>High</b>	Requires an immediate response (i.e. response within 48 hours) based on the information collected during the referral process. An urgent assessment is required if the person's safety is at risk (e.g. high risk of falls or abuse), or there is a high likelihood that the person will be hospitalised or required to leave their current residence because they are unable to care for themselves, or their carer is unavailable. This may be due to a crisis in the home involving either the client or the carer or a sudden change in the client or carer's, medical, physical, cognitive or psychological status.	3 calendar days	Within 48 hours
<b>Medium</b>	Information available at referral indicates that the client is not at immediate risk of harm. Referrals that indicate progressive deterioration in the client's physical, mental or functioning status, or that the level of care currently available to the client does not meet their needs or is not sustainable in the long-term, should be allocated to this priority category.	3 calendar days	Between 3 and 14 days
<b>Low</b>	Refers to cases where the referral information indicates that the client has sufficient support available at present, but that they require an assessment in anticipation of their future care requirements. Examples include the carer planning a holiday, which will result in the care recipient requiring the provision of substitute care or recognition that the person is having increased difficulty living independently and options for future care need to be discussed with the client and their carer or family. In deciding to use this category the ACAT is making a judgment that delaying an assessment for more than 14 calendar days will not jeopardise the client's health and well-being.	3 calendar days	More than 14 days up to 36 days.

### 8.3. First Clinical Intervention

First clinical intervention is first date that contact of a clinical nature (i.e. non-administrative) that is made between an ACAT and the person (or their representative), their carer, a service provider or a clinician in response to the person's referral for a Comprehensive Assessment.

### 8.4. Managing Referrals

Once a referral for assessment is issued, assessors can action by accepting, rejecting or transferring the referral. Note that the RAS business allocation counts all referrals issued to the RAS, regardless of the action (accept, reject or transfer). Where a referral is issued but is not at the status of accepted, rejected or transferred, the contact centre is able to recall the referral and if necessary reissue the referral. In this scenario, the team leader of the outlet will receive a system notification if a referral has been recalled.

Referral rejection decisions need to align with the referral principles and must place the client's interests as paramount. The Department monitors rejected referral rates and requires valid reasons for rejecting referrals. A referral may be rejected if it is outside the assessment region, however lack of organisational capacity is not a reason to reject a referral.

The assessor can reject or transfer a referral after acceptance. Once an assessor starts the assessment, they will need to cancel if they are not proceeding with the assessment.

The transfer functionality only applies to new assessment referrals and does not apply to support plan reviews. A referral can only be transferred once.

Support plan reviews must be completed by the assessment organisation that undertook the most recent assessment. If appropriate a support plan review may be cancelled.

If on accepting a referral more information about the client is received or there is a change in the client's circumstances, there may be a need to cancel the assessment. The following types of situations are examples where cancelling the assessment may be required. The client:

- has been admitted to hospital so the assessment is no longer required
- does not consent, withdraws their consent or is not seeking services.

### Good Practice Steps/Activities

- determine whether the referral is appropriate to be accepted
- referrals should only be rejected after careful consideration if there is valid reason not to proceed with the assessment or the assessor is unable to transfer the referral to another assessment organisation
- where the assessment organisation considers that the referral should have been issued to the alternative assessment pathway (i.e. either to the RAS if initially referred to an ACAT or to the ACAT if initially referred to a RAS), they should contact the respective RAS or ACAT to discuss the client's situation before transferring the referral in the system
- use notes to document key steps and record all of the referral information, including the reason why it was not accepted. This will ensure the relevant details are available if required for monitoring purposes or if a complaint arises.

#### 8.5. Duplicate records

This information applies to assessors who are able to undertake self-referrals and in doing so are required to register a client to prevent duplication of client records in My Aged Care.

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

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

### Good Practice Steps/Activities

When registering a client on My Aged Care, the assessor must always first search for a client record to see if they exist.

#### **Legal Name vs Preferred Name**

- When searching for a client to determine if they already have a My Aged Care client record, the assessor must ask if the client prefers to go by a name other than their legal name
- Conducting searches under each name can help to identify if a previously created record exists
- When a record does not exist and you are creating the record use the legal name in the first name field
- Once the record is created, add a preferred name in the field provided in the personal details section of the client record.

### **Additional information in name field**

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

### **Special Characters**

When completing the name fields for a client record only use the following characters:

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

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

### **8.6. Accepting the Referral**

When those allocated a team leader role receive a referral they should view the client information in order to gain a preliminary understanding of the client's situation. Doing so helps to:

- ensure that the client's preferences and choices are supported during the assessment
- matching the client with an assessor who has the appropriate level of expertise, cultural understanding and locational proximity helps to ensure the client is assessed in the most effective and timely manner, guided, where specified, by KPIs and other performance measures.

### **Good Practice Steps/Activities**

- On receiving an assessment referral, team leaders should view any relevant information relating the client's referral. Information can be sourced from the client record, including:
  - previous screening/assessment details
  - previous support plans
  - previous approvals
  - attachments e.g. hospital discharge summary
  - notes
  - interactions
  - primary contact/support person for the client

- check that the client's contact details are accurate and up to date in My Aged Care and amend as necessary. For clients who are approved and seeking home care package services the ACAT must ensure the accuracy of client contact information as this will make sure correspondence is received. This is particularly important for home care package clients as they have 56 days in which to enter a Home Care Agreement from the date they have been assigned a home care package.
- review information in the client record to:
  - consider the client's eligibility for aged care (CHSP and care types under the *Act*)
  - check whether a representative for the client has been established (including whether an 'Appointment of a Representative' form is included in the referral)
  - determine whether the referral has been made for the right assessment type and to the right outlet.
- review the priority assigned by the referrer and change if it does not align with the guidance on priority. Once a referral is received, it is important that clients are seen in a timely manner, especially those with urgent needs. For ACATs, consider timing of the first clinical intervention (*see 8.3 First Clinical Intervention*)
- as web-form referrals are automated to a **medium** priority, it is important to review the referral information and reassign the priority (if applicable) according to the client's needs. This will prevent urgent cases from being overlooked
- match the client to an assessor who can best meet the needs of the client. For example, an assessor:
  - of the same cultural background
  - who has the expertise to address the special needs of the client
- use 'Notes' in the system to document key steps or phone calls including date, time, assessor name, designation or additional information should the referral be cancelled.

Further information:

The Department of Health website for the [RAS Quick Reference Guide 3 Managing referrals for assessment and reviews](#) and [ACAT Quick Reference Guide 3 Managing referrals for assessments and support plan reviews](#)

### 8.7. Scheduling an Appointment

When scheduling an appointment, use the opportunity to speak to the client (or their representative) to confirm and update information within the client record, which helps the assessment organisation and client prepare for the assessment.

By involving representatives, assessors can ensure that clients who may lack the capability to provide accurate and relevant information (e.g. clients with cognitive impairment) are accurately assessed (*see 5.2 Representatives*).

Please note: clients with cognitive impairment or mental health issues may require the involvement of a representative. Where clients have lost the capacity to make decisions about personal, lifestyle and/or health-related matters, they will require an authorised representative to be established in My Aged Care.

#### Good Practice Steps/Activities

- contact the client (or representative)
- identify who you are and the organisation you are from
- advise them of the organisation you have received the referral from and the role your organisation plays (e.g. Home Support/ Comprehensive Assessment)
- provide information and set an expectation of what will happen at the assessment
- confirm consent and availability for assessment
- gather any additional information required including whether the client would like a support person present at the assessment (family member, carer, interpreter, etc.)
- check to see if anyone else in the house may require an assessment, as appropriate
- check to see if referrer and/or representatives also need to be contacted.
- make the appointment
- complete the Work, Health and Safety (WHS)/home safety risk screen and check for alerts and notes in the referral information on the My Aged Care record
- advise the client the name of the assessor who will be attending the assessment location (if possible)
- upload any additional client information to client record (e.g. WHS screen) and use notes to record assessment booking details
- organise interpreter (e.g. For translation services or Auslan if required).



## 9. Conducting the Assessment

### 9.1. Preparing for Assessment

Preparing adequately for the assessment will help to ensure that assessors are well informed and are using existing information. This will reduce the need for the client to retell their story.

#### Good Practice Steps/Activities

- allocate time in your schedule to review all information in the client record prior to attending the assessment
- for ACATs, access the Application for Care form (*see 14.3 Application for Care Form*)
- contact referrer or General Practitioner (GP) (if required and with client consent)
- with the client's consent, consider collection of information on client's medical condition, diagnosed by suitably qualified medical personnel (for ACAT)
- confirm if the client is receiving existing services from whom and for how long
- view the service finder to ensure you have up-to-date service information and availability
- find out what unfunded services are available in the client's area or other options for community engagement
- organise access to any Supplementary Assessment Tools that may be required
- download client information (if using myAssessor application)
- ensure you have relevant consumer information products e.g. brochures, booklets, checklists, income fee information etc. to leave with the client following the assessment if requested.

### 9.2. Attending the Assessment Location

If possible the initial assessment should be made in the client's usual accommodation setting to assist with the environmental, physical and social components of the assessment by observing the client's level of independence, functioning, and existing support arrangements in familiar surroundings. Due to the nature of transition care services, some assessments will occur in the hospital setting (*see 18.1 Transition Care Programme*).

Where face-to-face contact between the assessor and a client is not possible, for example, when assessing a client in a remote area or the client is inaccessible due to a seasonal weather event - a phone, video conference, telehealth or teleconference assessment may be undertaken. Another suitably qualified person (such as a local health worker) may attend the assessment with the client to assist the assessment process.

When first attending the assessment location, assessors should inform the client about the assessment process. This will help to ensure the client has the context to consent to the assessment. Assessors should also inform the client of potential

outcomes of the assessment. Setting expectations appropriately in this manner will help assessors to engage clients more effectively during the assessment.

### Assessment in a Hospital Setting

RAS assessments cannot take place in a hospital environment; therefore the RAS assessor should arrange an appointment with the client and schedule it to take place 1-2 days after discharge (where possible). This ensures the client's current needs and goals are being assessed. A RAS assessor may also refer a client to an ACAT for a Comprehensive Assessment (with the client's consent) where it is identified the client has more complex needs.

For those clients in hospital requiring an ACAT assessment, they should be assessed in the same way as those assessed at home, including consideration of the home environment and social issues. A client will need to be in a stable condition for a hospital based ACAT assessment to take place as this will ensure that the care needs of the client outside of the hospital can be accurately assessed and the most appropriate care services recommended.

In hospital assessments, the ACAT must ensure that a carer or other advocate is advised of the assessment in all circumstances, and should be present during an assessment where possible.

Approvals for all types of care can be made following an assessment in a hospital environment and there should be no presumption that older people will progress from hospital to residential care, as they may be able to return to their previous living arrangements. This is especially appropriate following an acute incident where the individual may benefit from a reablement approach or reassessment in the home environment after the acute phase.

ACATs need to be aware that for a client to be approved for the Transition Care Program the assessment must be conducted while the person is in hospital.

### Good Practice Steps/Activities

- be clear to the client who you are and your organisation/role as an assessor on behalf of My Aged Care
- explain the assessment process and provide the broader aged care context (e.g. the role of My Aged Care, CHSP, Home Care Packages Program, Residential Care)
- explain the consent that will be required e.g. for assessment and referrals
- for ACATs, ensure the client is medically stable to participate in the assessment (if in hospital).

### 9.3. Conducting the Assessment

Assessors must refer to the [NSAF User Guide](#) to ensure competency in the use of the NSAF and in the delivery of Home Support or Comprehensive Assessments.

Conducting the assessment with a conversational and motivational approach will allow the assessor to develop rapport with the client. When clients are encouraged to tell their story, it will enhance the quality of the conversation and the information collected by the assessor.

For ACATs, the assessment may require a multi-disciplinary approach. This can be achieved through case conferencing, joint assessments with other service providers where necessary, follow-up visits, cross referral, multi-disciplinary consultations, or appropriate delegation processes.

The provision of wellness and reablement approaches should be embedded in the assessment and support planning processes.

**Wellness** aims to promote independence and autonomy. It is based on the concept that even with frailty, chronic illness or disability; people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible. A wellness approach underpins all assessment and applies even when the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

A wellness approach draws on the wellness philosophy to inform a way of working with people. It therefore involves assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourages actions that promote a level of independence in daily living tasks, as well as reducing risks affecting the ability to live safely at home. It avoids 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves, or with less assistance, and to increase satisfaction with any gains made.

The wellness approach underpins all assessment and service provision and applies even when the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

**Reablement** aims to assist people to reach their goals and maximise their independence and autonomy. A key distinction from wellness is that reablement involves time-limited interventions targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities (*see 9.7 Delivering Reablement*).

### Good Practice Steps/Activities

Assessors must observe the client's activities to gain insight beyond information that is conveyed just verbally by the client or the representative.

Confirm the support the client has available to them:

- that they understand the role of the RAS or ACAT and the assessment process
- confirm client, representatives and their consent (*see 5 Privacy and Consent*)
- consider informal supports first (e.g. can a family member/neighbour clean your windows).

Use a conversational approach when interacting with the client:

- use a conversational approach when asking questions, rather than simply running through the assessment questions and ticking boxes
- ensure your conversation is undertaken in a manner that is respectful, non-judgmental and non-confrontational
- know when and how to best use closed, open, direct and indirect questioning
- use motivational interviewing techniques such as expressing empathy and eliciting self-motivational statements
- use active listening skills
- make eye contact with the client to ensure client is engaged with the process (unless culturally inappropriate to do so e.g. Aboriginal and/or Torres Strait Islanders)
- gauge the client's level of engagement in the assessment. Look for signs of fatigue or discomfort and adjust approach accordingly.

Use appropriate language when speaking with the client:

- use needs-focused language, explaining what could be short-term vs. long-term options to meet their needs
- use language that is positive and not dismissive
- use language that focuses on the client's strengths, abilities and what they want to achieve and how these could be further supported – a focus on independence
- reflect the conversation back to the client to ensure you have understood what was said/agreed.

Consider wellness and reablement:

- focus on elements of functional tasks that a client can complete, and discuss what specific assistance they would benefit from in order to complete the task
- discuss strategies a client can employ in order to more easily manage day-to-day tasks (e.g. transport planning to meet goals around the use of public transport to maintain usual activities)
- explore client's opportunity for reablement (e.g. can the client benefit from time-limited support to regain their functional capability?).

Collect further information through additional means where appropriate:

- observe the client completing tasks in the home ('show me' assessment)
- advise the client what was observed/seen during the task
- use validated tools to collect further information (e.g. Mini Nutritional Assessment).

Consider all care options:

- Consideration should be given to both the availability and the capability of services to meet the client's care needs
- Care options can include local supports, health and community services, CHSP, home care, residential care, TCP, STRC, respite services, other services subsidised under the *Act*.
- For home care package approvals, consideration should also be given as to whether the client has an immediate intention to access a package. You should discuss with the client and record them as 'not seeking services' if they are uncertain as to whether they need a home care package. You should then advise that if they change their mind at a later date, they can call My Aged Care to update their intentions to seek home care package services.

#### 9.4. Recording Assessment Information

Recording assessment information in a consistent and effective manner will help to ensure that the client's situation is accurately reflected. Recording assessment information in this manner will also make it more easily readable and usable for people who need to access it in the future.

Service providers will benefit from well-recorded, consistent assessment information, as this will allow them to locate and understand the client's service needs more easily.

##### Recording sensitive information about clients

Assessors may record sensitive information about a client by adding a 'sensitive note' on the client's record. This information will not display to providers or client's viewing their information through the My Aged Care client portal and will be visible only to assessors and Contact Centre Staff.

Sensitive notes should be used to record information that is of importance, but is not appropriate for all service providers interacting with the client to know. This includes information about:

- medical conditions such as HIV
- past abuse or concerns, or
- Issues the client may not want disclosed more broadly such as a history of drug or alcohol abuse.

Where a sensitive note exists, a provider will be presented with an indicator when viewing the client information through their My Aged Care portal, prompting them to contact the assessor or My Aged Care contact centre who may disclose the information contained within the sensitive note should it be applicable to the provider. For example, where it is recorded that a client is HIV positive, an assessor may be contacted by a garden maintenance provider and choose not to disclose the information, whereas if contacted by a personal care provider the assessor may have a duty of care to disclose the information.

### Sensitive client flag

The My Aged Care system also enables a registered client or representative to be flagged a 'sensitive client' if the client or representative requests that access to their information is limited, and the client or representative:

- works for My Aged Care or
- has a conflict of interest with My Aged Care staff or
- has provided reasonable justification to support that their identity and contact information is to be protected.

A client or their representative may request that they are made a 'sensitive client' through the My Aged Care contact centre. The request will be assessed by contact centre team leaders and if appropriate the client or representative's record will be flagged as 'Sensitive'.

Sensitive client details will still be available to assessors and service providers who are working with the client. Clients or representatives who are indicated as a 'sensitive client' will need to disclose this status to the contact centre at the time of their interaction, as the information is restricted and will require a team leader to access and edit the record.

### The audience of assessment information

Throughout the assessment process, assessors must ensure that information is recorded in the most appropriate manner and for the right audience.

#### *Primary Author: Assessors*

Assessment information should be completed from the assessor's perspective to ensure it:

- lays the foundation for creating the support plan
- minimises duplication between the assessment and support plan
- provides sufficient evidence for delegate decision (ACATs only):
  - delegates should read the full Comprehensive Assessment to ensure all pertinent assessment information is considered.

- delegates should review the 'Reason' field to ensure that any recommendations for High priority home care package approvals are appropriately evidenced.

### *Primary Audience: Clients*

The assessment information should be:

- transparent and reflective of what the client actually said
- easily understandable, aided by the use of common phrases, minimising the use of acronyms and presenting clinical information in lay language
- free of oversimplification to ensure adequate information is presented.

### *Key Audience: Service Providers*

Assessment information can help to inform a client's provision of care.

### Good Practice Steps/Activities

Focus on the client when recording assessment information:

- Make sure all important assessment information is recorded before leaving the client's home in order to prevent unnecessary follow-up queries.
- If using a computer at the client's home, sit where the client can see your screen and ensure you are not focused on just the computer. Ensure you regularly make eye contact with the client.
- Minimise use of acronyms, only using the more common acronyms where necessary.
- Tell the client's story – use the client's words where possible.

Completing the assessment:

- Ensure the full client story is recorded throughout the assessment.
- Consider how best to record information so that viewers of assessment information do not think that a question was skipped/ missed (e.g. use 'Not Applicable' where appropriate rather than leaving fields blank).
- Use Comments fields to identify where there is an inability to obtain information related to a certain profile.
- Minimise repetition in the assessment by using the areas of the NSAF that best suit the information.
- Use the myAssessor application (if appropriate).

## 9.5. Completing the Assessment Summary

Using a standard template (example in Table 3 ISBAR approach below) to complete the assessment summary can help to ensure information is recorded in a consistent manner, across both RAS and ACATs. It is simple to adopt and helps make information easier to read and better support the delegation process. This will also

benefit service providers by making it easier for them to access and interpret important assessment information in order to develop care plans.

There are several principles that should be adhered to when completing the assessment summary. The assessment summary should be:

1. Written in a succinct manner (using the ISBAR approach – see *Table 3*), focusing on relevant/essential information.
2. Presented in a structured way that makes the information easy to interpret.
3. Grammatically correct and free from acronyms, abbreviations, jargon and unnecessary headings.
4. Relevant. Only include information that is relevant to the client's current situation. This may mean updating previous information.

### The audience of the Assessment Summary

#### *Primary Author: Assessors*

Assessors may use the assessment summary to develop a succinct overview of assessment outcomes.

#### *Primary Audience: Clients*

Clients will receive this succinct, client-centred version of assessment information as part of their printed support plan.

#### *Secondary Audience: Service Providers*

Service providers benefit from the assessment summary as it presents an easy-to-read, focused snapshot of key information and client goals.



### Good Practice Steps/Activities

Use the template below to guide the development of an assessment summary. Currently this template is not built into the My Aged Care system.

**Table 3 Assessment summary template using the ISBAR approach**

ISBAR topic	Assessment information
<b><u>I</u>ntroduction</b>	<ul style="list-style-type: none"> <li>• Client's name and age</li> <li>• Reason for assessment, including referral details (who made the referral and why, if appropriate)</li> <li>• Assessment details – date, location, attendees</li> </ul>
<b><u>S</u>ituation</b>	<ul style="list-style-type: none"> <li>• Current social situation</li> <li>• Key health conditions that impact functional limitations</li> <li>• Medical issues (ACATs to include diagnosis status)</li> </ul>
<b><u>B</u>ackground</b>	<ul style="list-style-type: none"> <li>• Living arrangements</li> <li>• Social history</li> <li>• Current support               <ul style="list-style-type: none"> <li>○ Carer support (including details of Power of Attorney in place)</li> <li>○ Other informal supports</li> <li>○ Current services</li> </ul> </li> </ul>
<b><u>A</u>ssessment</b>	<ul style="list-style-type: none"> <li>• Carer situation</li> <li>• Function/mobility</li> <li>• Impact of function/health conditions</li> <li>• Cognition status</li> <li>• Behavioural issues</li> <li>• Outcomes of Supplementary Assessment Tools (if used)</li> <li>• Identification of unmet needs</li> </ul>
<b><u>R</u>ecommendations</b>	<ul style="list-style-type: none"> <li>• Previous approvals</li> <li>• Current recommendations               <ul style="list-style-type: none"> <li>○ Reason for the recommendation (the client benefit from X)</li> <li>○ Comments relating to the priority/urgency of services</li> <li>○ Who is to action the recommendation – client, assessor</li> <li>○ Recommendations associated with the carer</li> </ul> </li> <li>• Referrals               <ul style="list-style-type: none"> <li>○ Status of referral (e.g. referral made with consent, client declined referral)</li> <li>○ Who is responsible for contacting the services</li> </ul> </li> <li>• Review date</li> <li>• Contact details (if not client)</li> <li>• Who has been sent a copy of the support plan</li> </ul>

## 9.6. Developing a Support Plan

Developing a support plan with the client will ensure it accurately reflects the client's needs and goals. This will increase the likelihood that the client will work towards the goals they have identified, including the wellness approach and reablement interventions identified throughout the assessment. It will also help to illustrate the client's situation which will in turn help providers to better understand the client's needs and preferences.

### The audience of the Support Plan

#### *Key Audience/Author: Clients*

The support plan should be based on the client's own stated goals, concerns, and preferences.

It is important that the support plan is considered as an ongoing document that can be updated as a client's needs change.

#### *Facilitating Authors: Assessors*

Assessors must make sure the client's story is articulated into a documented set of goals (short and long term with a wellness and reablement approach).

#### *Key User/Audience: Service Providers*

The support plan should:

- provide a simple snapshot of the referral outcome to make it easier for service providers to access relevant information
- inform the development of a care plan.

### Good Practice Steps/Activities

- Develop the support plan with the client and obtain their agreement (although it may be documented when back at the office).
- Establish client motivations, client goals/concerns and recommendations for all clients and record them from the client perspective and with consideration of a wellness approach.
- Ensure recommendations are for services and supports for current needs and not recommending services that are not supported by the assessment or are anticipated future needs.
- Agree with or change the priority for service recommendation included in the support plan based on the client's needs and urgency for services. The determination of urgency for services is based on the client's circumstances that there is an urgent need for an assessment which, if not met immediately, may place the client's health and safety at risk. Note that for home care package approvals, a change in priority (as defined in the [Guidance on Priority for Home Care Services](#)) will require a new assessment with associated Delegate approval.

- Document general recommendations (i.e. non-CHSP services, client actions).
- Remove use of acronyms and abbreviations.
- Build and maintain effective working relationships with service providers and extend connections with services and organisations in their local community including those not listed on the My Aged Care website.
- Assessors can access service provider contact details in the My Aged Care Service Finder. Service providers will find the name of a client's assessing outlet in the 'Plans' tab of the client record.

### 9.7. Delivering Reablement (RAS)

Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. A key distinction is that reablement involves time-limited interventions that are more targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Supports could include training in a new skill, modification to a person's home environment or having access to equipment or assistive technology.

As part of the assessment process, the assessor will need to work with the client to identify whether they would benefit from a reablement approach to home support services, based on their preferences and needs. It is anticipated that 10% of assessed clients will be referred to short-term reablement support services.

If the client agrees that short-term reablement support is appropriate and beneficial to them, the assessor should include service solutions within the support plan which promote their independence. The assessor is able to record the reason for reablement period within the support plan such as:

- rebuild confidence and independence in mobility
- support the development/relearning of daily activities
- task simplification and energy conservation for managing housework
- promote social contact, community access and integration
- skills development in using public transport
- to supporting independence through assessment for appropriate aids and equipment
- training in the use of assistive technology
- helping people to manage personal finances
- other.

The support plan must include services which assist the client to maintain and/or strengthen their capacity to continue to undertake daily activities, and maintain social and community connections. Because of the nature of reablement services, it is possible there will be several items in the support plan that need to be delivered in a coordinated way to a number of service types over a limited time period. In these

circumstances, the assessor could refer a client to a lead provider, the organisation or individual provider who will deliver the key services in the support plan.

The assessor might also need to take on a coordination role to ensure that all services in the support plan are linked to a provider and that they will all be delivered in the time frame of the overall reablement service. For clients receiving reablement support, assessors must include review dates on the client's support plan for the purposes of reviewing the client's progress towards their goals and desired outcomes, requirement for ongoing services, or whether to adjust the services required.

The reablement function on My Aged Care (currently for RAS) is designed so that the support plan can be finalised and kept open for the support period to allow additional edits to be made and the timeliness KPI will not be impacted. The timeliness KPI ends at the "Finalise support plan & keep open for support period". For a smaller sub-set of older people, restorative care may also be appropriate, where assessment indicates that the client has potential to make a functional gain. Restorative care involves evidence-based interventions led by an allied health worker or professional that allows a person to make a functional gain or improvement after a setback, or in order to avoid a preventable injury (*see 15.3 CHSP Restorative Services*).

#### Good Practice Steps/Activities for Facilitating Reablement

- Consider if the client would benefit from short-term reablement support, particularly if the client has experienced some functional loss and expresses the desire to regain confidence and capacity to resume activities, including connecting with their community.
- If reablement is provided by the home support assessor, recommend a period of reablement on the client's support plan. This function allows Home Support Assessors to identify clients who would benefit from reablement, and allow assessors to make changes to the client's support plan during the reablement period.
- Furthermore, users accessing the client's record, such as clients and service providers, will be informed that the client is undergoing a period of linking support and/or reablement.
- Consider the client's need for a mix of short-term, episodic or ongoing services across service types (e.g. short-term personal care, episodic allied health, ongoing transport). Review this approach regularly to ensure the intensity of services matches the client's needs.
- Maintain regular contact with the client and providers and during the period of reablement.
- In consultation, determine when the reablement period should be finalised, and what ongoing support (if any) may be required for the client.
- Develop local knowledge of reablement-type services in the region. Discuss with local providers their capacity and willingness to take on short-term clients as part of a reablement episode.

Further information:

[Guidance on Priority for Home Care Services](#)

The Department of Health website for the [Linking support and reablement fact sheet](#)

Ch 2. [CHSP Manual effective July 2018](#) and [Living well at home. CHSP Good Practice Guide](#)

## 9.8. Delivering Linking Support/Care Coordination to Vulnerable Clients

Most clients will be able to be assisted by assessors through the match and refer process offered through My Aged Care however facilitating linking support can greatly benefit some clients. Where an older person's issues or circumstances may impede their access to aged care services, provision of linking support will assist in linking the client to one or more services they require in order to live with dignity, safety and independence. These may be formal or informal services. Linking support may also be seen as short-term case management or care coordination to the point of effective referral (see *10.3 Supporting a Successful Match and Refer Process*).

Linking support activities are aimed at working with the client to address areas of vulnerability that are preventing access to receiving mainstream aged care support or care, to the extent that the client is willing or able to access aged care services. Issues leading to vulnerability could include homelessness, mental health concerns, drug and alcohol issues, elder and systems abuse, neglect, financial disadvantage and cognitive decline and living in a remote location.

The NSAF is designed to assist the assessor in identifying the complexity of a client that may require linking support, however assessor judgment also plays a significant role - noting the presence of the same risk in different people may signify varying degrees of vulnerability.

The level of linking service support offered by assessors is time-limited, and is not designed to provide ongoing support services. The activities that an assessor chooses to undertake when providing linking support will be dependent on the needs, circumstances and preferences of the client and may include one or more of the following:

- **Information provision and tailored advice** – provision of clear, reliable, up-to-date and relevant information and advice to clients regarding service options and pathways.
- **Guided referral** – facilitation and management of the process of linking a vulnerable client to appropriate service pathways within or outside the aged care system. This includes monitoring the success of the referral process, and ensuring that linking to the appropriate services is achieved

- **Service coordination** – where a client’s needs are complex and require a range of services spanning a number of sectors, the assessment organisation oversees the coordination of these services.
- **Advocacy activities** – in order for the vulnerable client to gain access to the identified support services, the assessment organisation may be required to speak, act and write to the identified service providers on behalf of the vulnerable client
- **Case conferencing/multidisciplinary service coordination** – provision of comprehensive, integrated service coordination for clients with high intensity needs. This involves using a case conferencing/multidisciplinary service coordination approach which brings together a number of team members and a suite of services across sectors in order to meet the client’s needs at different levels
- **Establish local knowledge and networks** – the assessment organisation establishes local connections with service providers which support vulnerable people in their region.
- **Administrative tasks** – establish and undertake the administrative functions necessary to support the smooth and seamless progression of the vulnerable client through the required services. Some examples are:
  - Contact the relevant service providers on behalf of the client (e.g. legal services, health services, housing services etc.)
  - Obtaining the necessary client information from various sources and organisations
  - Compiling and completing the necessary forms on the client’s behalf
  - Organising relocation services for the client, if required (e.g. removalist and utility services)
  - Organising cleaning services for the client’s place of residence, if required
  - Documenting the client’s progress.

Assessors may work closely with the Assistance with Care and Housing Sub-Program of the CHSP service providers in the management of vulnerable clients on a low income who are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation (*see 15.4 Assistance with Care and Housing Sub-Program*).

The linking function on My Aged Care (currently for RAS) is designed so that the support plan can be finalised and kept open for the support period and the timeliness KPI will not be impacted. The timeliness KPI ends at the ‘Finalise support plan & keep open for support period’. The Department’s expected proportion is that RAS deliver linking support to at least 2 per cent of clients.

### Vulnerable clients relating to home care packages

For those home care package clients that an ACAT assessor wishes to monitor more closely, assessors can elect to be notified of home care correspondence sent to the client. This particularly applies to vulnerable clients who need assistance with the process of finding a suitable provider and do not have the support to assist them. Only one person from an outlet can be selected to receive this notification. This person's contact details will also appear on all client correspondence relating to their home care package assignment.

This notification can be enabled from any tab in the client's support plan or on the 'Approvals' tab in the client record. The notification link will only be enabled if the client has been marked as 'Seeking services' or a home care package recommendation has been made (see *16 Home Care*).

### Good Practice Steps/Activities

- Consider if linking support is likely to be required, particularly if the client presents with two or more complexities.
- Advocate having services within and outside aged care organised for the client.
- Access relevant experts to address the client's complexities (e.g. Assistance with Care and Housing providers, community Geriatric Evaluation and Management (GEM) teams, advocates, social or mental health workers) and to assist with the co-ordination of the client's care whilst receiving linking support.
- Discuss with service providers the client's current situation and support plan moving forward.
- Maintain regular contact with the client, providers and those co-ordinating services during the period of linking support.
- In consultation, determine when the linking support period should be finalised, and what ongoing support (if any) may be required for the client.
- If linking support is provided by the Home Support Assessor, recommend a period of linking support on the client's support plan. This function allows Home Support Assessors to identify clients who would benefit from linking support, and allow assessors to make changes to the client's support plan during the linking support period.
- For home care package clients that the ACAT assessor is monitoring closely (or at the client or representative's request), the assessor is able to extend the client's take-up deadline beyond the 56 day entry period and extend the clients time to select a provider for an additional 28 days through the extension process on My Aged Care.
- Furthermore, users accessing the client's record, such as clients and service providers, will be informed that the client is undergoing a period of linking support.

Further information:

The Department of Health website for the [Linking support and reablement fact sheet](#)

### 9.9. Assessment Wrap-Up

At the end of the assessment, an assessor should inform the client of the next steps so they have a realistic expectation of what will occur following the assessment. This will help the client to feel more assured and increase their satisfaction in the overall assessment experience.

#### Good Practice Steps/Activities

- Inform the client on the next steps, such as:
  - who to contact and in what instance (i.e. if the client has chosen to be matched and referred to service/s, they will be contacted by service providers to discuss details of the service being requested; if the client has chosen to receive a referral code, they will need to take the code to the provider of their choice to access the service)
  - the actions they are responsible for (e.g. visiting providers, organising a check-up with a GP/specialist)
  - for clients seeking access to the Home Care Packages Program, how the national queue works including to opt in or out of the queue, where to go to start researching providers and to find out how much they may be asked to contribute to the cost of their care; and what action they should take once they have been allocated a package.
- Leave behind a client information pack/form as written information on what will happen next.
- Provide contact details to the client on who they should contact in the future (e.g. the contact centre, the assessment organisation [name and contact details of the assessor], and one or more service providers).

Further information:

The Department of Health website for the [NSAF Fact Sheet Feb 2017](#) and [NSAF User Guide Feb 2017](#)



## 10. After Assessment

### 10.1. Finalising Assessment Information

Finalising assessment information, including ensuring no information is missing, will help to ensure that the client story, including their needs, goals and preferences is conveyed accurately and actioned upon in the agreed manner.

#### Good Practice Steps/Activities

- Perform a quality check on the assessment information, expanding on information and assessment evidence where required.
- Ensure that there is consistent information across assessment and support plan documentation e.g. if there is a recommendation made for respite, ensure that there is clear information on the client/carer relationship, any difficulties or concerns that are experienced and the sustainability of the relationship. Or, if there is a recommendation for a high priority home care package approval that you include appropriate justification in the dedicated reason field.
- Identify triggers to refer on to specialist assessment e.g. allied health, occupational therapy (OT) assessment.
- Contact GP (if necessary and with client consent).

### 10.2. Completing Delegation (ACAT only)

Delegates should review all assessment information carefully to ensure their decision results in the approval of the most appropriate care types to address the client's needs (*see 13 Delegation*).

Reasons for all approval decisions under the *Act* must be clearly recorded in the client record. Where a recommendation has been made for a high priority home care package approval, delegates must check that a sufficient reason has been included and that the recommendation can be appropriately justified by information captured in the assessment and support plan.

#### Good Practice Steps/Activities

- Gather further information from the assessor who conducted the assessment (if needed)
- Apply a multi-disciplinary approach
- The assessment information and support plan must contain clear evidence of decisions made by the delegate. For home care approvals, this must include the recording any decisions for a high home care priority on My Aged Care and in client correspondence such as the Approval letter or the notice of priority for home care services (*see 14.9 Outcome of Decisions and 21 Right of Review*).

### 10.3. Supporting a Successful Match and Refer Process

An assessor must ensure that clients are matched with service providers according to the client's preferred area/location of service delivery, needs and preferences, and that proposed service options are discussed with the client.

Checking information such as service availability during the match and refer process will help to ensure service referrals are actioned in a timely manner, and client choice and preferences are facilitated.

To assist in broadening support options for the client, assessors should build and maintain effective working relationships with service providers and extend connections with services and organisations in their local community including those not listed on My Aged Care.

Assessors may send referrals electronically to one or more Commonwealth-funded service providers of the client's choice, or provide the client with a referral code for the client to self-manage the referral.

For residential and CHSP services, a referral code is generally issued following the assessment and approval of services to enable the client to take time to look for a suitable facility or provider. A referral code for Home Care will only be issued to a client once they have been assigned a Home Care Package from the national prioritisation system. The referral code will be included in their home care package assignment letter that they can present directly to their preferred provider or can request assistance from the My Aged Care contact centre or the ACAT for assistance in issuing to a provider(s).

If a client has a preference for a particular service provider who does not have availability, the client can elect to be referred to that service provider's waitlist on the system (if a waitlist is available). Clients may be on a number of waitlists at any one time.

Where a service is not available to meet the needs of the client and the client does not want to be put on a waitlist, the assessor should have a further conversation with the client in order to consider other alternative options for support. Other options may include:

- a different Commonwealth-funded service that could meet the need (on an interim or ongoing basis)
- non-Commonwealth-funded services
- the client and/or their carer/representative being able to address part of their need.

Where required, the assessor is to provide short-term assistance to the client for the purpose of implementing the support plan. This may include monitoring referrals or discussing options with service providers for the provision of alternative services if necessary. In cases of vulnerable clients, this may include providing linking support or care coordination.

The role of the assessor is finalised when an effective referral has been made or where the client has made a choice not to proceed with aged care services or to manage their own referrals.

An effective referral is where:

- a referral is accepted by a service provider
- the client has accepted responsibility for managing their own referral or
- the outcome of the assessment is that no further action is required by the RAS or ACAT.

Where the Department becomes aware that a client is experiencing difficulty with accessing services, an assessment organisation may be required to follow-up with the client or service provider and provide advice on any follow-up action/s taken.

#### Good Practice Steps/Activities

- Check availability of service providers in the client's region.
- If required (for example, for vulnerable clients) contact providers on behalf of clients when referring.
- Add additional Notes to ensure all pertinent information is available to service providers.
- Consider all referral options (broadcast, preference, direct referral).
- Consider referrals to services not listed within My Aged Care.
- Advise the initial referral source of the outcome of assessment, delegation (if relevant) and referral.

#### 10.4. Providing the Client with Assessment Outcomes

Providing the client with adequate information relating to their assessment outcomes will ensure the client has a clear understanding of what will happen following the assessment, including who will contact them or who they will need to contact.

#### Good Practice Steps/Activities

Provide the client with a copy of their:

- support plan
- referral code letter (if appropriate, noting that home care package clients will receive a letter once they have been assigned a package)

- satisfaction survey (if applicable)
- in addition, for clients who had a Comprehensive Assessment, a copy of the approval or non-approval letter or other associated notification documents.

### 10.5. Follow-up

Following up with clients who may require further assistance, such as with actioning referral codes, will help to ensure the client is receiving the services that address their needs. A follow up may also assist vulnerable clients who experience more difficulty in accessing the services they require.

#### Good Practice Steps/Activities

If appropriate, follow up with clients post-assessment who:

- are issued with a referral code
- have referrals that have been rejected/not actioned
- are working on short-term reablement goal(s) – in line with the length of time stipulated in the support plan
- are vulnerable, as determined by complexity indicators or need for linking support.

### 10.6. Support Plan Review and New Assessment

A review by an assessor relates to the effectiveness and appropriateness of the client's support plan. The aim of the review is to ensure clients receive a smooth, consistent experience in a timely manner, and to avoid unnecessary assessment. An assessor may set a review date on the support plan at the time of the assessment. A review may also be requested by a client or a service provider. It may be completed over-the-phone with the client.

The majority of support plan reviews are to be completed within 10 days. The Department supports assessment organisations actioning requests in this timeframe, noting that some review requests may need to be actioned more urgently than others (as specified within the request indicated by providers or by the contact centre). In addition, to ensure priority is given to clients with the greatest need, assessors must balance the completion of support plan reviews with new assessments.

#### Key Principles

1. Assessors are best-placed to make the decision as to whether a client requires new assessment following a review. This decision is supported by the information provided by the client, the contact centre, service providers and health professionals.
2. Where there is a significant change in a client's needs or circumstances which affect the objectives or scope of the existing support plan, a new assessment

may be undertaken. A new assessment can be the outcome of a support plan review.

3. In relation to timing, for RAS, a support plan review may be appropriate if it has been less than 12 months since the last assessment. A new assessment may be required if it has been more than 12 months since the last assessment, following completion of a support plan review.
4. The most appropriate way for a service provider to request a support plan review or new assessment for a client is through the provider portal.
5. A review request will be referred to the assessment organisation that undertook the most recent assessment.
6. When conducting an assessment, assessors should be considering the current needs of the client, and not recommending services that aren't supported by the assessment.
7. Assessors must reach the point of effective referral prior to finalising the support plan.

### Review or new assessment

A client may require a support plan review in the following instances:

- informal care arrangements have changed/ceased
- client's needs have not changed, but a specialist health professional has indicated that there is a need for additional services
- services are required prior to a client moving to a new location (this is to be followed with a referral for new assessment by local assessment organisation).

A client may require a new assessment following a support plan review in the following instances:

- client has multiple new needs or significantly increased needs
- client requires *Act*-based services for the first time (refer for Comprehensive Assessment)
- client requires further *Act*-based services in addition to their existing approvals (refer for Comprehensive Assessment)
- client needs another episode of STRC.

A client may require a reassessment at the request of a Department delegate relating to a reconsideration of an ACAT delegate decision (*See 21.3 Role of the ACAT in the reconsideration process*).

## Review process

The contact centre and service providers should look to include the following information when requesting a support plan review or new assessment:

- Why the request has been made (i.e. client's circumstance)?
- What is the request for (e.g. service type) and why it is needed (e.g. client's change in needs or goals)?
- If the request is urgent, why it is urgent.

Consider the most appropriate action following a support plan review request:

- The review request may be cancelled by an assessor and a support plan review not undertaken if it is inappropriate or insufficient information is provided to warrant a review
- The assessor may determine that no changes to the support plan are required as the existing support plan meets the clients' needs
- The assessor may determine that the existing support plan needs to be updated to recommend additional services
- The assessor may determine that the clients' needs or circumstances have changed significantly since their original assessment and a new assessment is required.
- After considering the request for the support plan review, the assessor should consider possible outcomes including cancelling the request, determining that no changes to the support plan are required as it meets the clients' needs, updating the current plan or conducting a new assessment.

A review by an assessor will look at the following aspects:

- The reason a review has been requested and its impact on the client's existing assessment information and support plan.
- The appropriateness of the services in meeting the client's goals.
- Any new goals for the client and associated referral(s) for service.
- The appropriateness of setting another review date or an end date for service delivery.

An assessor is to record the outcome of the support plan review when selecting 'Complete & finalise support plan review'. After selecting 'Complete & finalise support plan review' no further changes can be made to the Support Plan as part of the review.

A client can have multiple reviews of their support plan. Assessors should consider whether the client requires a new copy of the Support plan as a result of a review.

Further information:

The Department of Health website for the [Conducting a review of a client's support plan fact sheet](#), the [Support Plan Review and New Assessment Key Principles and Guidance](#) and the [How to manage a support plan review request](#) video.

## 11. People with Special Needs

To assist in achieving more equitable access to assessment and aged services, section 11-3 of the *Act* identifies the following special needs groups:

- people from Aboriginal and Torres Strait Islander communities
- people from culturally and linguistically diverse backgrounds
- people who live in rural or remote areas
- people who are financially or socially disadvantaged
- veterans
- people who are homeless or at risk of becoming homeless
- care-leavers
- parents separated from their children by forced adoption or removal
- lesbian, gay, bisexual, transgender and intersex people.

The special needs of these groups are described in more detail in this section.

Assessors should also be aware of the *Aged Care Diversity Framework*. The Framework is an overarching set of principles designed to ensure an accessible aged care system where people, regardless of their individual social, cultural, linguistic, religious, spiritual, psychological, medical and care needs are able to access respectful and inclusive aged care services.

Further information:

The Department of Health [website](#) for the Aged Care Diversity Framework December 2017

### 11.1. Aboriginal and Torres Strait Islander People

An assessment of an Aboriginal and/or Torres Strait Islander person should be carried out in a culturally sensitive and appropriate manner. It is recommended to match the client to an assessor who can best meet their needs, an assessor of the same cultural background or an assessor who has knowledge of the local region and culture. Assessors should observe local protocols and create a culturally safe environment for the assessment process. This may include involving a trusted person nominated by the client in the assessment process to support the client or facilitate assessment (e.g. Aboriginal Health Worker or carer).

Assessors should develop a good understanding of the communities in which they operate as this ensures the advice and assistance provided to clients is appropriate for their needs and takes into account any local sensitivities. Assessors should establish links with Aboriginal and Torres Strait Islander community and health services and consider engaging with health workers whom the client knows as they may be able to assist with the assessment.

Assessors are required to complete Self-Paced Learning Experiences for Working with Aboriginal and Torres Strait Islander People (*See 26 Training*). It is also recommended that assessors seek additional cultural safety training relevant to the customs and protocols local to the area in which they are working.

### 11.2. People from Culturally and Linguistically Diverse (CALD) Backgrounds

Assessors in areas with culturally diverse populations must engage workers from relevant backgrounds where the client agrees and such workers are available. To ensure an accurate exchange of information during assessment, independent and qualified interpreters should be used to assist people who do not use English as their main language. Client or carer consent regarding the use of an interpreter must be sought in all cases.

Assessors are required to complete Self-Paced Learning Experiences for Working with CALD People (*see 26 Training*).

Assessors should be aware of and extend connection with culturally appropriate aged care services for these clients in their region. Assessors may also use the services of specialised workers for older people from culturally diverse backgrounds.

Organisations such as local migrant resource centres, the Federation of Ethnic Communities' Councils of Australia (FECCA) and Partners in Culturally Appropriate Care (PICAC) can provide more information.

From 2012 to 2017, the *National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse (CALD) Backgrounds* informed the way the Australian Government supported the aged care sector to deliver care that is appropriate and sensitive to the needs of older people from CALD backgrounds. The Strategy formally concluded on 30 June 2017 but it remains a valuable resource. A new action plan for people from CALD backgrounds will be developed under the *Aged Care Diversity Framework* by mid-2018.

#### Further information:

The Department of Health [website](#) for information on People from diverse backgrounds includes the [National Ageing and Aged Care Strategy for People from CALD backgrounds](#) and the report into its implementation, as well as information about the [PICAC](#) program & the FECCA [website](#)



### 11.3. People who live in Remote and Very Remote areas

A small number of clients live in isolated areas. Whilst recognising face-to-face assessment is best practice and should be the first option, this mode of assessment is not always possible. In these circumstances, assessments may be conducted using non face-to-face technologies such as by telephone or telehealth. Where this occurs, a suitably qualified person from within the local health service or community care provider should be present to support the client and to facilitate the assessment.

Assessors should develop and maintain good working relationships with health and community workers in rural and remote communities who may be called upon to assist with assessments and provide information and community needs and local services.

### 11.4. People who are Financially or Socially Disadvantaged

Financial or social disadvantage can often create a significant barrier for people to access a wide range of services in the community. Assessors should ensure that they develop and promote links with organisations in their area which attempt to overcome these barriers, and provide assessments to people who may benefit from services regardless of their financial or social circumstances.

People who are financially or socially disadvantaged may also experience difficulties in accessing services after their approval. Assessors should be prepared to engage in a wider range of care coordination activities on behalf of these clients to ensure that they receive the care which they need and to which they are entitled.

A person's access to aged care must not be affected by their ability to pay consumer fees, but should be based on the need for care, and the capacity of the provider to meet that need.

Further information: Section 22.5 Financial hardship

### 11.5. Veterans and War Widows and Widowers

The Australian Government recognises the special aged care needs of the veteran community, in particular, mental health issues, including post-traumatic stress. This is creating demand for a wider range of health care and support services in residential and home care services.

Assessors should establish links with relevant veterans' organisations in their communities and develop links between veterans and home care and residential care services. They should aim to facilitate an understanding of veterans' particular needs and to improve integrated care and access.

Assessors should have a good understanding of services provided by the Department of Veterans' Affairs (DVA) including the Veterans' Home Care (VHC) Program, the Coordinated Veterans' Care (CVC) Program and other mental health and rehabilitation programs (see 19.2 DVA).

Assessors should advise veterans that if they are a former Prisoner of War or Victoria Cross recipient, DVA will pay their fees for Home Care Packages, CHSP, Transition Care and STRC.

Further information: The DVA [website](#)

### 11.6. Care Leavers

The Department's website provides information on care leavers, including a description of the term 'care-leaver':

This term refers to children who were in institutional and other out of home care prior to the year 2000, including:

**Forgotten Australians** - people who spent a period of time as children in children's homes, orphanages and other forms of out-of-home care prior to the year 2000; and

**Former Child Migrants** - children who arrived in Australia through historical child migration schemes and were subsequently placed in homes and orphanages.

**Stolen Generations** - children of Australian Aboriginal and Torres Strait Islander descent who were removed from their families and communities by federal and state government agencies from the late 1800s to the 1970s.

Care leavers are recognised as people with special needs under the *Act*.

Assessors should be particularly sensitive to the effects of care-leavers' childhood experiences with government officials, authorities and institutional care. Assessors should emphasise that clients' wishes are taken into account, they can have a support

person at the assessment and they are not obliged to take up any approved care (see *17.1 Permanent Residential Care*).

In December 2016, the *Caring for Forgotten Australians, Former Child Migrants and Stolen Generations* resource was launched. This package is designed to enhance aged care services and ensure residential and home care providers provide the best possible care to the care leaver groups.

Further information:

The Department of Health [website](#) for the *Caring for Forgotten Australians, Former Child Migrants and Stolen Generations* booklet

### 11.7. Parents Separated from their Children by Forced Adoption or Removal

'Parents separated from their children by forced adoption or removal' are recognised as people with special needs under the *Act*.

This term refers to the policies and practices that resulted in forced adoptions and the removal of children throughout Australia, particularly during the mid-twentieth century.

Forced adoption practices impacted a large number of Australians and caused significant ongoing effects for many people, particularly mothers, fathers and adoptees.

Assessors need to be particularly sensitive to those clients who have been adopted or impacted by past forced adoption practices, including interactions with government officials, authorities and institutional care, as these experiences can have significant personal and psychological impacts. Assessors should emphasise that clients' wishes are taken into account, they can have a support person at the assessment and they are not obliged to take up any approved care.

Further information: The Department of Social Services [website](#) for forced adoption resources and support services

### 11.8. Lesbians, Gay, Bisexual, Transgender and Intersex people (LGBTI)

LGBTI clients are recognised as people with special needs under the *Act*.

Assessors should ensure they conduct a non-judgmental assessment and the choice to disclose or sexual orientation or sex/gender identity is entirely the client's decision. Where a client does disclose this information, the Assessor should emphasise that the information is protected information under the *Act*. In the case of transgender and intersex clients, where specific medical history may need to be communicated to service providers, it is important to discuss the way this information will be provided to the providers.

Assessors should also be aware of service providers who provide LGBTI specific services and those that are LGBTI inclusive, and be prepared to advocate for LGBTI clients with other service providers as necessary as part of their care coordination activities.

The *National Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Ageing and Aged Care Strategy* is an initiative put in place by the Australian Government to ensure that LGBTI people have the same opportunities and options in aged care that are available to all Australians.

Further information:

Special needs groups Part 2-2, Division 11, Section 11-3 [Aged Care Act 1997](#)

The Department of Health website for the [National Lesbian, Gay, Bisexual, Transgender and Intersex \(LGBTI\) Ageing and Aged Care Strategy](#) and [LGBTI ageing and aged care resources](#)

## 12. Other Groups

### 12.1. Carers

Assessors are to recognise the valuable contribution and informal support that carers provide in the care of older people.

Where possible, with the clients consent, the Assessor should involve the client's carer, family or other nominated representative in the assessment and support planning process. In assessing the client's care needs where family and carers are involved, assessors may find there is a need to balance the client's concerns and preferences with those of their family and/or carers.

Assessors should (with the clients consent) gain an understanding of the carer's support preferences for the client and their capacity to continue in the caring role. Assessors need to consider the carer's circumstances and assess if there are any factors that may affect the sustainability of the caring role. Assessors should provide information to carers regarding specific support services that are available – for carers to access and how to link with these support services (see *19.3 Carer Programs*).

Assessors are required to complete Self-Paced Learning Experiences for Working with Carers and the Care Relationship (see *26 Training*).

Further information:

The Carer Gateway [website](#)

## 12.2. People with Mental Illness

Older people with a mental illness may seek entry to aged care services. Assessors are encouraged to liaise with mental health services to assist their understanding of the needs of older people with mental illness. Assessors can also assist by facilitating links between clients, providers and appropriate mental health services.

Aged care services usually do not have the capacity to adequately meet the needs of people with a serious uncontrolled mental illness without the support of, and treatment by, mental health services. People who are a danger to themselves or others may not be suitable for entry to an approved aged care service.

Assessment and approval for entry to aged care is only appropriate if the intensity, type and model of care is the most appropriate to meet the person's care needs. This includes the following considerations:

- The person meets the eligibility criteria set out in the *Act and Approval of Care Recipients Principles 2014* or CHSP assessment criteria.
- The person's mental health is stable. If they have recently received treatment, their mental health should be stable prior to being assessed although it is understood they may still have significant symptoms.
- Community mental health services will continue to provide collaborative care for those elderly people who have significant or unstable psychiatric symptoms.

The assessor must, prior to commencing an assessment, obtain informed consent for the assessment either from the person, if they have the capacity to do so, or a decision maker consistent with state guardianship legislation who is able to make decisions regarding health, accommodation and daily living care.

Involuntary mental health care is governed by separate mental health legislation in each state and territory. People who are placed under some form of an involuntary order (e.g. to manage their medicines when living in the community) may be eligible for aged care services. Assessors should consider each referral on a case by case basis.

In some jurisdictions, under certain circumstances, mental health legislation empowers the treating psychiatrist to make accommodation decisions in the best interests of a person receiving treatment under an involuntary order. This power is only exercised when a particular accommodation setting is required to facilitate the treatment of a person's mental illness. It does not replace the need for guardianship when mental illness is incidental to that person's need for placement in residential care.

An ACAT assessment is also required to access residential aged care facilities in jurisdictions where residential aged care facilities are part of the aged mental health service system.

All jurisdictions should develop assessment protocols that reflect relevant state or territory legislation and regulations, to ensure that older people with a mental illness are directed to the responsible agency to assess and recommend services most appropriate to meet their care and support needs.

### 12.3. Young People seeking Aged Care Services

There is no age restriction limiting the delivery of Commonwealth subsidised aged care services under the *Act*. A younger person is generally considered to be under the age of 65, or 50 for Aboriginal and Torres Strait Islander people.

The assessor is responsible for determining whether or not a younger person is eligible to receive aged care services under the *Act*. For a person to be eligible to receive aged care services under the *Act*, aged care legislation requires that there are no other care facilities or care services more appropriate to meet the person's needs (the *Aged Care Principles 2014*).

For clarification of assessment pathways taking place with the National Disability Insurance Scheme (NDIS) rollout assessors should refer to the Aged Care Assessment Supplementary Guidelines for Younger People with Disability.

Prematurely aged people aged 50 years and over (or 45 and over for Aboriginal and Torres Strait Islander people) on a low income who are homeless or at risk of becoming homeless may be eligible for CHSP. See 12.4 for further information about eligibility under CHSP.

Further information: The Aged Care Assessment Supplementary Guidelines for Younger People with Disability (to be published as part of this Manual shortly)

The NDIS [website](#) and the Department of Health [website](#) for younger people in aged care

### 12.4. People who are Homeless or at Risk of Becoming Homeless

Although homelessness is not recognised as a special need under the *Act*, assessors have a responsibility to recognise clients who are homeless, or at risk of becoming homeless, and to ensure that they are able to access an assessment and any aged care services approved for them. Liaisons between assessors and support services for homeless people are particularly important for this cohort because of their extreme vulnerability.

Under the CHSP, the Assistance with Care and Housing (ACH) Sub-Programme supports older people or prematurely aged people aged 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) who are on a low

income and who are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation. Assessors should take particular care to understand the client's usual living arrangements and their particular circumstances when arranging an assessment and assessing the person for care.

Assessors should also be aware that homelessness alone is not grounds to approve a client as eligible for residential or other forms of aged care. The person should meet the eligibility criteria set out in the *Act and Approval of Care Recipients Principles 2014*.

Where housing assistance services are not available, assessors should be prepared to make appropriate referrals and work with their state and territory government housing and homeless services.

Homeless means people who are:

- a) without any acceptable roof over their head e.g. living on the streets, under bridges, in deserted buildings etc. (absolute homelessness or 'sleeping rough')
- b) moving between various forms of temporary or medium-term shelter such as hostels, refuges, boarding houses or friends
- c) constrained to living permanently in single rooms in private boarding houses or
- d) housed without conditions of home e.g. security, safety, or adequate standards (includes squatting).

Definition of homeless is in the CHSP Manual for the Assistance with Care and Housing (ACH) Sub- Programme

Further information: The Federal Register of Legislation [website](#) for the *Approval of Care Recipient Principles 2014*

The Department of Health [website](#) for the Assistance with care and housing sub-programme

## 12.5. People with Dementia

The Australian Government recognises the special needs of people with dementia and their carers. Assessors should foster links with dementia specific services, including Dementia Behaviour Management Advisory Services (DBMAS), and where relevant, include this expertise in the assessment process. This will facilitate an understanding of the needs of ageing people with dementia and their carers and assist improved linkages, integrated care and access.

Assessors must use their professional judgment if a client has dementia or is confused. In these cases, the input of carers and/or advocates is particularly important. Note that assessors should be aware that applying professional judgement

might be especially difficult when dealing with patients from CALD backgrounds who might be suffering from dementia due to language barriers, lack of awareness of dementia among family members or due to stigma attached to dementia with some cultures. Some culturally appropriate dementia resources are included under further information below.

Assessors may find the National Health and Medical Research Council (NHMRC) approved Clinical Practice Guidelines and Principles of Care for People with Dementia (the Guidelines) useful. The Guidelines provide recommendations for the diagnosis and management of dementia and are intended for use by staff working with people living with dementia in the health and aged care sectors, including general practitioners.

A companion document to the Guidelines for people living with dementia and their carers is titled *Diagnosis, treatment and care for people with dementia: A consumer companion guide*.

### [Services and supports for people living with dementia, their carers and the health and aged care workforces](#)

- Counselling, education and training through the National Dementia Support Program delivered by Dementia Australia (formerly Alzheimer's Australia) can be accessed by contacting the National Dementia Helpline on **1800 100 500**.
- The Wicking Dementia Research and Education Centre at the University of Tasmania offer two online courses known as MOOCs (Massive Open Online Courses): Understanding Dementia and Preventing Dementia.
- DBMAS provides locally based support and advice to aged care, acute care and primary health providers as well as individuals caring for people living with dementia where behavioural and psychological symptoms of dementia (BPSD) are impacting on their care and quality of life. Where a person in Commonwealth-funded residential aged care is experiencing severe and extreme BPSD, DBMAS can refer them to the Severe Behaviour Response Teams (SBRTs) for more specialised support. Family carers and providers can contact the 24 hour DBMAS helpline for advice on **1800 699 799**.
- Accredited education, upskilling and continuing professional development for the workforce providing dementia care in the primary, acute and aged care sectors through Dementia Training Australia.
- The Australian Government is also establishing Specialist Dementia Care Units (currently in development as at March 2018).



Further information:

The NHMRC [website](#) for the Clinical Practice Guidelines and Principles of Care for People with Dementia

The University of Sydney [website](#) for the Cognitive Decline Partnership Centre

The Massive Open Online Courses [website](#) Understanding Dementia and Preventing Dementia

The Dementia Training Australia [website](#) for Dementia care resources for CALD communities

The Dementia Australia [website](#) for culturally appropriate dementia assessment tools

## PART C - DELEGATION AND APPROVAL PROCESSES UNDER THE *AGED CARE ACT 1997* (ACAT ONLY)

### 13. Delegations

Under Part 2.3 of the *Act*, the Secretary has the power to approve a person as a recipient of Commonwealth-subsidised aged care. Under subsection 96-2(5) of the *Act*, the Secretary has delegated the power under Part 2.3 of the *Act* to positions within ACATs.

The Secretary delegates powers and functions to individual ACAT positions, not to individual ACAT members. The occupants of those positions are known as ‘ACAT delegates’ (delegate). The delegate can approve a person as eligible to receive different types of aged care.

Once powers and functions have been delegated to positions, state and territory governments are able to nominate individuals to occupy those positions. The Secretary also delegates powers and functions under sections of the *Act* to Department delegates.

#### 13.1. Delegation Rounds

ACAT delegations are updated biannually. This update involves the revoking of previous instruments of delegation and remaking a consolidated instrument under the *Act* and the Principles. Attached to the instrument of delegation under the *Act* is a Schedule for each state and territory, which identifies the positions to which the functions under the *Act* and Principles are being delegated.

#### 13.2. Principles of Delegation

The following principles of delegation underpin the delegation framework:

- Delegates must comply with all applicable Australian Government and state or territory laws which include, but are not limited to:
  - The *Act* and associated Principles.
  - The *Privacy Act*.
- Delegates are accountable to the Commonwealth in the role of approving consumer eligibility for access to subsidised aged care. Delegates for the Secretary of the Australian Government Department of Health have important responsibilities under the *Aged Care Act 1997*. Making decisions under delegation is a serious responsibility. A delegate can make dramatic changes to another person’s life circumstances and must act with commensurate responsibility and robust accountability.

- Delegates must approve a person as a care recipient if they are satisfied the person is eligible for that type and level of care, requires the care, and it is appropriate to their needs. At the same time there is to be consideration of relativity to ensure decisions around access to aged care support are targeted towards the people with the greatest need.
- The objects of the *Act* include the need to ensure access to affordable and appropriate care targeted towards people with the greatest need, and to consider equity and merit in accessing the limited resources available to support services and programs under the *Act*.
- Delegates are required to take a broad view of their responsibility for the assessment of the relative needs of clients across their region, state or territory as well as the national context.
- The composition of delegates within any one team should reflect the multidisciplinary approach and should include a mix of disciplines drawn from the core assessment professions.
- It is strongly advised that the approving delegate does not perform the role of the assessor, noting that in situations such as rural and remote locations, this may not be always possible.
- In approving a care recipient to receive Commonwealth subsidised aged care, the delegate must be satisfied that the person is eligible for the type of care approved. The delegate must be satisfied that the ACAT has:
  - Conducted the assessment in accordance with relevant legislation and guidelines
  - Conducted a holistic assessment, including assessment of the person's usual living arrangements
  - Ensured that a multidisciplinary approach was taken and involved the disciplines required to assess different aspects of a person's care needs
  - Recommend the care types and services for which the person is eligible and that is most suitable to meet their current care needs and wishes
  - Involved the client (carer, representative and/or advocate as appropriate) in the assessment process
  - Collected adequate verbal or written assessment information, sufficient to address any queries the delegate may have
  - Conducted a quality check of the information captured prior to submitting their recommendation to the delegate for approval.

- The delegate should ensure that the Comprehensive Assessment has been completed without errors, contradictions or omissions before approving the care. Where the delegate is not satisfied, the delegate is responsible for obtaining the additional information required to make a fully informed judgment.
- The delegate should complete a final quality check to ensure that the approval decision is clearly supported via evidence captured during the assessment and for home care package approvals, where a high priority is being approved; the reason field contains a suitable justification of the priority.
- Delegates must ensure reasons for their decisions are recorded in the client record and that the client is notified of these reasons in any correspondence relating to the outcomes of the assessment. The delegate is able to discuss decisions with clients and family should there be any concerns. They should be able, if asked, to provide further information to the Commonwealth delegate when there is a right of review application. If required, the delegate is available to appear before the Administrative Appeals Tribunal to give evidence in support of a decision, in the event that an appeal is made.
- Delegation to positions will be subject to the continued operation of the ACAT according to Commonwealth guidelines, funding conditions and any directions issued by the Secretary to the Secretary's delegates.

### 13.3. Good practice principles for quality management of ACAT decisions

Consistent with an ACAT's delegated responsibilities as outlined in Section 13.2, a quality management approach should be undertaken that supports the three-tiered approach to quality management. This approach consists of:

- Tier 1 - checking assessments and decisions before they are finalised to ensure that the NSAF has been completed such that the decision is clearly justifiable to the delegate and for future record; and that the NSAF is completed as a quality document (e.g. information is complete, contains no typos or grammatical errors, acronyms are not used etc.).
- Tier 2 - after the fact quality audits by ACATs/Delegates - this comprises using the NSAF self-audit tool to assess the quality of completed NSAFs. It could also incorporate other in-house quality auditing approaches within ACAT organisations/jurisdictions.
- Tier 3 – Audits authorised by the Department. The audits may include relevant information submitted by ACATs as part of their regular reporting or ensure appropriate records are kept and evidence is available to support decisions. This may involve a random review of selected assessments to check the quality and

evidence-base. The purpose of such activity is not to assess the decision itself but to validate that decisions have been clearly evidenced and align with information captured during the assessment.

#### 13.4. Occupants of Delegate Positions and Nomination Process

Once delegate positions have been established through the delegation round, individual ACAT members can be nominated to occupy those positions by their team manager. This nomination must be requested and endorsed through the relevant state or territory government ACAP manager.

The Department will discuss and clarify any issues with the state or territory government as required. If the Department accepts the nomination, the Delegate's information will be established to allow access to the My Aged Care assessment portal with delegate role access.

#### 13.5. Delegate Selection Criteria

The Department has set selection criteria to ensure that ACAT members have appropriate levels of experience, knowledge and skills to competently undertake the delegate role. Nominees will need to meet the below selection criteria to be considered and occupy delegate positions:

1. Is employed 0.5 full time equivalent (FTE) or greater on the ACAP.
2. Is an employee on the ACAT Program for at least 12 months.
3. On practical assessment. The person is routinely engaged in the full spectrum of ACAT work including community and hospital assessments.
4. One of the core disciplines for the ACAT (note the numeric profession code which forms part of the Delegate Position ID):
  - 1) Medical Practitioner
  - 2) Registered Nurse
  - 3) Social Worker
  - 4) Occupational Therapist
  - 5) Physiotherapist
  - 6) Other
  - 7) Psychologist
5. Has successfully completed National Delegation Training (mandatory).

The Department and state and territory ACAP managers will liaise on particular circumstances where for the effective operation of a team (such as small or rural remote teams) some flexibility in the application of the criteria is required.

In accordance with state or territory government regulations, delegates should disclose and take reasonable steps to avoid any conflict of interest (real or apparent). Types of interest and relationships that may need to be disclosed include shareholdings, gifts, employment, voluntary work, company directorships or

partnerships that could or could be perceived to impact upon the delegate's decision-making powers.

### 13.6. Delegate ID

Delegate positions are identified using a 6 character code:

- Characters 1 – 3 are the ACAT ID
- Character 4 is the profession ID as listed in section 13.4 *Criterion 4*
- Characters 5 – 6 are numbers identifying the position within the ACAT.

For example, the delegate position 6SR315 is in the Southern ACAT in Tasmania, can only be occupied by a Social Worker, and is identified by the position number 15 in that ACAT.

### 13.7. Changes of Occupant in Delegate Position

Although changes to delegate positions can only be made during the delegation rounds, changes to the occupant of a delegate position can be made at any time. ACATs should contact their state or territory manager with change requests to take a delegate on or off a position. The manager will liaise with the Department on the changes. Agreed changes will be updated on My Aged Care.

## 14. Approval Process

### 14.1. Overview

Subsection 22-4(1) of the *Act* states that "Before deciding whether to approve a person, the Secretary must ensure the care needs of the person have been assessed".

The assessment and approval processes are separate functions and there can be no assumption that assessment automatically leads to a person's approval as a care recipient.

### 14.2. Eligibility

A person is eligible for approval for care if the person meets the eligibility requirements under Division 21 of the *Act* and Part 2 of the *Approval of Care Recipient Principles 2014*.

Under Section 22-1 (2) the *Act*, to be eligible for a type of care, an ACAT delegate must approve a client for a particular type (or types) of care:

- if the person has made an application in writing to be approved as a recipient (*see 14.2 Eligibility*) and
- they are satisfied through the assessment information collected that the person meets the eligibility criteria for that type (or types) of care and

- the type (or types) of care being approved are the most appropriate to meet the person's care needs.

Where a person is determined as not meeting the eligibility requirements of any care program under the *Act*, the assessment would result in 'No Care Approved'. The specific eligibility requirements for the different types of care and the limitations that can be placed on approvals are set out in the *Act* and in the Principles. To inform these decisions, assessors should take into account all the assessment information collected through the NSAF and if applying for home care, the findings from the [Guidance Framework for Home Care Package Level](#). For assessments where no care under the *Act* is approved, assessors may also recommend other forms of care and support, for example CHSP if available and suitable, or local/state based services.

Once approved a client is eligible to receive Commonwealth-subsidised care from an approved provider if they choose to do so.

ACAT assessors will need to consider legislative exclusions for certain types of care that may have a number of criteria that need to be met. For example, a person is not eligible for STRC if they are currently receiving a home care package.

Assessors and delegates should refer to Part D for further information on assessment and eligibility for Commonwealth subsidised aged care.

### 14.3. Application for Care Form

The [Application for Care form](#) is the Secretary's approved form used by a person (or if there are exceptional circumstances by another person) to request approval for one or more types of care (see Subsection 22-3 of the *Act*). The form also sets out that the ACAT can provide information to service providers and can be used by the provider for an emergency case application (see 14.8 *Urgent Circumstances*).

The legislation does not limit who the other person is and the interpretation of 'other' should not be prohibitive. At times the client will not have a legal representative or guardian – or such a person cannot be present - so another person acting in the interests of the client can do this, for example, a spouse or other close relative, close friend, general practitioner or solicitor.

Once the person has applied for care and been approved, there is no requirement that a new request form be completed at any future point once an approval has been granted. For example once a person has submitted a Secretary's approved Application for Care form, the approved care recipient is not required to complete a new form if they want to vary the limitations on the approval such a residential respite care level or a change in home care priority. However consent requirements must be adhered when undertaking any assessment (see 5.3 *Consent*).

A person must complete a new Application for Care form if their approval ceases to have effect under section 23-1 of the *Act*, and the person requires approval to be a care recipient again.

The form is available through the My Aged Care assessor and provider portals or at [Application for Care form](#). When completed, the form is uploaded as an attachment to the My Aged Care client record.

#### 14.4. Approval as a Care Recipient

The approval of a person as a recipient of aged care services specified in the *Act* is a central ACAT function.

The Secretary must approve a person as a recipient of one or more of those types of aged care if:

- an application is made under section 22-3 and
- the Secretary is satisfied that the person is eligible to receive that type of aged care (see Division 21 of the *Act*).

#### 14.5. Types of Care

An ACAT approval is required for the following types of Commonwealth subsidised aged care services under the *Act*:

- Home Care (*see 16 Home Care*)
  - Level 1
  - Level 2
  - Level 3
  - Level 4
- Residential aged care (permanent and/or respite) (*see 17 Residential Care*)
- Flexible Care in the form of Transition Care (*see 18.1 Transition Care Programme*)  
or
- Flexible Care in the form of STRC (*see 18.2 Short-Term Restorative Care*)

However, ACATs can refer to a variety of other aged care services that do not require approval, such as those provided by a Multi-Purpose Service (MPS) or a service funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme (NATSIFAC) or CHSP.

Clients should be advised that a person is not compelled to enter residential aged care or accept a home care package or any other service recommended by an ACAT once eligibility has been determined.

Similarly, clients should be made aware that being approved for an aged care service does not ensure the availability of that service and be informed how the national queue for a home care package works.



## 14.6. Limitation of Approvals

In some circumstances, the delegate may limit an approval for a specified period, such as time limiting an approval where the delegate foresees an improvement to the client's condition meaning the person is not likely to require that level or type of care. This should be considered, in particular with a view to:

- reablement and wellness approaches
- likely recovery from hospitalisation or acute medical condition/s, or
- Improvements from other supports or interventions.

A delegate can limit an approval to an aged care service of a particular kind. A delegate can also time limit an approval and/or limit flexible care to transition care, or residential care to residential respite care. Where the person is approved for home care, the delegate can determine the priority to be medium or high. In addition, a delegate can limit an approval to a level of care, such as for residential respite to a low or high level of care.

The delegate may also, at any time, vary any limitation. The date the variation takes effect is the date the new decision to vary the limitation is approved.

Limitations and variations to the limitation of an approval should be clearly specified in the client's approval letter (see 14.9 *Outcome of Decisions*).

Subsection 22-2 of the *Act* and Part 3 of the Approval of Care Recipient Principles 2014 deals with the limitation of approvals. The Secretary's functions under subsections (1), (3) and (4) are delegated to ACAT positions. Limitations of approvals are reviewable under Part 6.1 of the *Act*.

## 14.7. Date of Effect of Approval

Under section 22-5(1) of the *Act*, an approval takes effect on the day on which the Secretary approves the person as a care recipient.

**Under the Act, an approval cannot be backdated.** There is one provision that allows a person urgently needed care to be provided with that care if it was not possible to gain an approval beforehand (see Section 22-5 (2) of the *Act* and Section 14.8 Urgent Circumstances (see 14.8)).

In the event that a system issue prevents the delegate from recording their approval decisions on My Aged Care, the delegate is required to use the Offline Approval form (accessed through the My Aged Care assessor portal) to manually record their decision/s. The approval takes effect on the day on which the delegate signs and dates this form. If the client needs to enter care, and the system issue is outstanding, this form provides evidence to the provider of the approval. When possible, the completed and signed form must be uploaded to the client's record via the assessor portal. When the system is operating, the delegate must record the approval including

the actual date of delegation in My Aged Care. This information is transmitted to the Department of Human Services (DHS).

#### 14.8. Urgent Circumstances

There are some circumstances where a person urgently needs care under the *Act* and approval is not possible before the client entered into aged care. Urgent circumstances usually apply in the context of residential care and residential respite care. If the delegate agrees to the urgent circumstances, the legislation allows them to record the date of effect of the approval from the date that the urgent care started.

From 27 February 2017, urgent circumstances do not apply to home care. A home care provider is not eligible to receive home care subsidy until a person has been assigned a home care package through My Aged Care and entered into a home care agreement with the provider (under Part 3.2 section 46-1 of the [Act](#)).

#### Application Process

To be considered for a Commonwealth subsidy in urgent circumstances, the approved provider must submit an [Application for Care form](#) to their local ACAT within five business days after the day on which the care started. This form can be accessed from the Department's website or via the assessor and provider portals.

If the provider is not able to submit the form to the ACAT within the five business days, the provider may request an extension from the ACAT delegate who has the power to grant or reject the extension application.

If the extension is rejected, the service provider can seek a review of the decision as determinations of periods and rejections of applications are reviewable under Item 24, Part 6.1 of the *Act* (see *21 Right of Review*).

#### Intake and Assessment Process

When the ACAT receives the Application for Care form:

- Ensure the Application for Care form is signed by the client, or other person, and that the 'emergency case' box is completed correctly by the approved provider.
- Confirm the date of receipt of form. If the form is received outside the 5 business days after the care started, the ACAT can only proceed with the assessment when they confirm that the provider has been granted the extension from the ACAT delegate.

- Register and self-refer the client via the assessor portal (if required).
- Assign the priority on intake. Although the person is now receiving care, the ACAT needs to take into account the urgent circumstances of the individual case when determining priority as they may need to conduct the assessment as soon as possible.
- Upload the checked and receipted Application for Care form on My Aged Care.
- Schedule an assessment with the client. This face-to-face assessment (if possible) should collect information:
  - on the client's eligibility as a recipient of aged care and type of care required
  - that supports the circumstances that an emergency existed at the time the client entered care and that it was not possible to obtain prior approval.

It is required that the assessor to gather as much information as possible about the urgent situation from the client, the carer (if available), the service provider and any other professional who was involved at the time.

### Delegate Process for Urgent Circumstances

In order to consider approval for the placement of a client in urgent care, the delegate must determine the following:

- the application process meets requirements
- the client is eligible for the type of care being provided and the client urgently needed the care at the time the care started and
- it was not possible to obtain approval beforehand.

If emergency care is approved, the ACAT will need to action the following:

- Check the emergency care flag and enter the date of admission to care on My Aged Care – this will ensure the approved provider receives subsidy from the date of entering care. If a delegate determines that an emergency did not exist but the client is still eligible for approval as a care recipient, the date of effect of the approval will be the date that approval was granted. Send the referral to the provider via the assessor portal. This enables the provider to access the client record and see all the approval details.

There are some situations that are not considered urgent and therefore should not be approved as urgent admissions. This may include a bed becoming available in a residential aged care facility or moving from an acute care setting to another care setting.

Decisions about when a person urgently needed care are reviewable under Part 6.1 of the *Act* (See 21 *Right of Review*).

### Client dies prior to ACAT Assessment

When a client has entered into residential care as an emergency and dies before the ACAT conducts the assessment, the delegate cannot make any decisions on the emergency, or the care, or the person's eligibility for care. In this circumstance the approved provider still sends the Application for Care form to the ACAT who will contact their state or territory manager. The manager will escalate the case to the Department.

The Department delegate is able to make the decision to approve or not approve eligibility for aged care and approval that an emergency care situation existed under the *Act*. The Department will notify the approved provider of their decision and if approved, liaise with DHS to enter approval information on DHS payments systems so that the provider is able receive the subsidy for the care provided.

Where the ACAT assessor has completed an assessment and the client dies after the assessment but before the delegate has made their decision, the ACAT delegate can proceed and make the decision to approve or not approve care. The approval is recorded on My Aged Care and submitted to DHS.

### 14.9. Outcome of Decisions

Delegates must ensure reasons for their decisions are clearly evident in the NSAF including the support plan and any associated client correspondence. For high priority home care decisions, delegates are to record the reason to justify this decision when making the approval on My Aged Care.

Delegates have a legal obligation to notify clients of the decision to approve or not approve them as recipients of Commonwealth-subsidised aged care. This obligation is set out in the *Act* under sections 22-6 'Notification of Decisions' and 85-3 'Secretary must give reasons for reviewable decisions'.

The approval and non-approval template letters are produced after the assessment and delegation process is finalised. Delegates are also required to provide a printed copy of the client's support plan to the client with the notification letter. Delegates should be aware that the templates include information about the client's review rights.

See Part E Complaints Section 20 and right of review Section 21

### 14.10. Approvals that Cease to Have Effect

#### Approvals that Expire

A subsidy cannot be paid to an approved provider for providing care to a person, unless the person is approved under the *Act* as a care recipient and has a valid approval. If an approval has expired, the person is no longer approved for care and, if receiving care, is no longer able to receive that care.

Approved providers must check that the care recipient has a current approval for the care type and level they will be providing when a care recipient:

- moves from one service to another
- changes their care type
- needs a higher-level of care
- has a time-limit on their approval
- has a break in care.

ACATs should be aware that a provider cannot receive subsidy for a day where a resident does not have valid approval for the care type received. The ACAT needs to take reasonable steps to ensure clients and providers are aware of any limitations on the approval.

ACATs should refer to the Reassessment Table at Appendix 3 as a guide to check to whether an approval is valid or the person requires a reassessment. ACATs and providers are advised to access DHS payments systems to check if an approval has expired. If an ACAT member needs access to the DHS payment system, they should ask their state or territory manager for more information on the process.

For difficult cases, ACATs should seek further advice from the Department through their state or territory manager. Administrative errors made by assessment organisations around approvals may result in Act of Grace claims which are managed by the Department of Finance.

### Approvals that Lapse

Approvals for certain types of care can lapse under certain conditions such as if care is not provided within the entry period. This applies to TCP and STRC. For more information on lapsing conditions see Part D 18.1 Transition Care and 18.2 STRC.

Approvals for the following types of care do not lapse unless they are time-limited:

- residential care (permanent and/or respite care)
- home care.

### Approvals that are revoked

A client's approval can be revoked if, after ensuring that the client's care needs have been assessed, the Secretary is satisfied that the client has ceased to be eligible to receive a type of aged care for which they are approved. This power is delegated to Department delegates (not ACAT delegates). On the rare occasions that revocation is being considered, the Department delegate will liaise with the ACAT to ensure that the necessary assessment is made.

Section 23-4 of the *Act* sets out the process for revocation of an approval. A new approval for care does not revoke previous approvals.

### 14.11. Corrections Process

The delegate is responsible to ensure that their decisions are recorded correctly on My Aged Care e.g. correct dates, including the date of approval, type of care, level of care, any limitations on the approval. These quality checks will minimise the need to make correction changes on the system.

However if an administrative error does occur, My Aged Care has a correction process. For example, there could be an error in recording an approval for low level respite care on My Aged Care when the decision is to approve high level respite care; or the date of approval on My Aged Care does not reflect the correct decision date.

Where a delegate has recorded an incorrect decision on a client's record, they must request a 'correction' to this decision. Corrections are requested via the assessor portal to the Department for consideration within 42 days of the original decision.

The reason for the correction must be recorded when lodging the request. For example, "Home care package Level 2 omitted from online approval process, evidence of a Level 2 recommendation in support plan". For the Department to agree to the correction, the delegate's intention, as at the time the decision is made, should be evident through assessment documentation or other supporting documents on My Aged Care.

If the assessment information is not consistent with the correction request, the Department will reject the request. In instances where an individual's needs change after the original decision, it is required that a new assessment is undertaken.

A correction cannot be requested where service referrals have been issued for *Act* based services. Where a correction is required for an assessment and service referrals have been issued, the ACAT must recall all services in an 'issued' state before they can request a correction.

If the delegate requires a correction on an assessment where referrals have been accepted or commenced, the delegate must raise a case through to the My Aged Care provider and assessor helpline on **1800 836 799**. ACATs must provide details justifying why the correction should be undertaken despite a provider already commencing service provision. These cases will be escalated to the Department for consideration, noting that the outcome of such a correction may trigger Act of Grace claims.

Further information:

The Department of Health website for:

[QRG 10 Delegate Processes](#)

[Guidance Framework for Home Care Package Level](#)

[Application for Care form](#)

[Emergency Case application](#)

The Federal Register of Legislation website for:

[Aged Care Act 1997](#) Part 2.3: Applications for approval Division 22-3; Eligibility Division 21; Revocation of approvals, Section 23-4; Date of effect, Urgent Circumstances Division 22-5; Limitation on approval Section 22-2. Home care subsidy eligibility Part 3.2 Section 46-1.

Urgent Circumstances Part 4, Section 13 Limitation on Approvals Part 3, [Approval of Care Recipients Principles 2014](#)

The Department of Finance [website](#) for Act of Grace

## PART D – TYPES OF COMMONWEALTH-SUBSIDISED AGED CARE

Part D contains important information for all assessors and delegates, in order to be able to determine eligibility for Commonwealth subsidised aged care (See 14.2 *Eligibility*).

### 15. Commonwealth Home Support Programme (CHSP)

The CHSP provides funding for a broad range of entry-level support services to assist frail older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional (including cognitive) limitations, to remain living independently at home and in their community.

CHSP services are delivered on a short-term, episodic or ongoing basis, with a strong focus on activities that support independence and social connectedness and taking into account each person's individual goals, preferences and choices.

The CHSP is designed to provide small amounts of support services in a timely manner to older people who have difficulty performing activities of daily living without help due to functional limitations. Services funded under the CHSP include domestic assistance, transport, meals personal care, home maintenance and modifications, social support, nursing and allied health.

In recognition of the vital role that carers play, the CHSP also supports care relationships through providing planned respite care services for frail older people which allows regular carers to take a break from their usual caring responsibilities.

#### 15.1. CHSP Target Groups

All new CHSP clients will access services through My Aged Care. Target groups for the CHSP are:

- Frail older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need assistance with daily living to remain living independently at home and in the community.
- Frail older Commonwealth Home Support clients aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander people) who need planned respite services, to provide their regular carers with a break from their usual caring duties.
- Frail older people or prematurely aged people 50 years and over (or 45 years and over for Aboriginal and Torres Strait Islander people) on a low income who are homeless or at risk of homelessness as a result of experiencing housing stress or not having secure accommodation.



## 15.2. Definition of 'Entry-level' Support

As an 'entry-level' program, the CHSP is designed to provide relatively low intensity (small amounts) of a single service or a few services to a large number of frail older people who need only a small amount of assistance or support to enable them to maintain their independence, continue living safely in their homes and participating in their communities.

The CHSP is not designed for older people with more intensive, multiple or complex needs, nor is it intended to replace or fund support services provided for under other systems such as the health care system. These higher needs are generally supported through other aged care programs including the Home Care Packages (HCP) program, residential aged care and through the health care system, including through early intervention, rehabilitation, subacute and transition programs.

CHSP services delivered to a client are generally expected to be, in total, lower than the cost or volume of services provided under a Level 1 home care package (less than \$8,000 per annum). For example, the significant majority of CHSP clients should only require small amounts of one or two support services.

A higher intensity of episodic or short-term services may also be provided where improvements in function or capacity can be made, or further deterioration avoided. For example where a client experiences a temporary setback such as a fall and requires a period of more intensive support to regain their independence. Higher intensity services should only be provided on a short-term basis under the CHSP. Clients who require higher intensity levels of ongoing care and support are considered to be out-of-scope for this program. In addition, where a client requires ongoing case management to provide a coordinated package of care and services, this is out-of-scope for the CHSP.

## 15.3. CHSP Restorative Services

Time-limited 'restorative-type' interventions are targeted towards a person's specific goal or desired outcome to adapt to some functional loss, or to regain confidence and capacity to resume activities. Restorative care interventions implemented through the CHSP will be coordinated by providers of allied health and therapy services that will help clients set (functional) goals and review their progress after a defined period. This may involve a multidisciplinary approach with assessors and services working in an integrated way.

### Client scenario – Entry-level support – JOYCE

Joyce's son comes to visit her and notices that she is not eating well and seems low in spirits. When they talk about it, Joyce reveals that her closest friend has moved interstate to live with family. Joyce misses her friend's company and is feeling lonely. Since she no longer drives, she has not been to see her other friends at the local seniors' centre.

Joyce and her son call the My Aged Care contact centre and she consents to register as a client and create a client record. The contact centre organises for Joyce to receive a face-to-face RAS assessment.

The RAS assessor talks to Joyce about her needs and goals and establishes a support plan that includes:

- appointments with a CHSP funded accredited dietician on a short-term basis (to address nutrition issues).
- community transport to the local seniors' centre where Joyce will see her friends again.

This entry-level support helps Joyce to re-connect with her community, improve her physical and emotional health and continue living in her own home.

#### 15.4. Assistance with Care and Housing Sub-Program

The Assistance with Care and Housing Sub-Program of the CHSP is designed to support those who are homeless or at risk of homelessness, to access appropriate and sustainable housing as well as community care and other support services, specifically targeted at avoiding homelessness or reducing the impact of homelessness.

Assessment organisations are required to work collaboratively with Assistance with Care and Housing Sub-Program service providers in supporting clients to access aged care due to their particular circumstances. Assistance with Care and Housing providers can help clients contact the My Aged Care contact centre and work with the assessment organisation, particularly during the assessment process. It is also appropriate for the assessor to refer suitable clients identified during the assessment process to the Assistance with Care and Housing Sub-Program for further support after an assessment.

In areas where the Assistance with Care and Housing Sub-Program is not available, the assessment organisation may be required to provide linking support to assist vulnerable clients who are homeless or at risk of homelessness (*See 9.8 Delivering Linking Support/Care Coordination to Vulnerable Clients*).

#### 15.5. CHSP Interaction with Home Care Packages

The care needs of a person receiving a home care package should be addressed through their home care package, and any CHSP service types (e.g. meals, transport, nursing) delivered to them would generally be paid for on a full cost-recovery basis from the home care package client's individualised budget.

This is intended to ensure that the CHSP is able to provide entry-level support services to as broad a population as possible (given that in most cases this will be the only form of support that people receiving CHSP services access), and recognises

that home care package clients already receive an individualised budget that they control, with which they can purchase the types of services offered under the CHSP.

There are three defined circumstances in which a home care package client may be able to access some specific CHSP subsidised services in addition to the services they are receiving from their home care package budget. The additional CHSP services will not be charged to the client's individualised home care package budget however the client will be expected to contribute to the cost of these services in line with the CHSP provider's client contribution policy.

In all three circumstances the additional CHSP services must only be provided on a short-term, time limited basis, which should be monitored and reviewed by the client's most recent assessment service. The three defined circumstances include:

1. For clients on a Level 1 or 2 home care package: where the home care package client's budget is already fully allocated, the client can access additional, short-term or episodic Allied Health and Therapy services or Nursing services from the CHSP, where these specific services may assist the client to get back on their feet after a setback (such as a fall).
2. For clients on a Level 1 to 4 home care package: where the client's budget is already fully allocated and a carer requires it, a home care package client can access additional planned respite services under the CHSP (on a short term basis).
3. For clients on a Level 1 to 4 home care package: in an emergency (such as when a carer is not able to maintain their caring role), where the client's budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short term basis. These instances must be time limited, monitored and reviewed.

Where a new client has been assessed and approved as eligible for a home care package but is waiting to receive that package, the client may be eligible to receive some services under the CHSP as an interim arrangement, but only to an entry-level of support consistent with the CHSP, not at the level of support of the package they are eligible for.

All home care package clients must be assessed through My Aged Care to receive these additional CHSP services. This assessment should be undertaken by the assessment organisation that undertook the most recent assessment of the client, which in most instances will be an ACAT. The additional services provided must be in line with the circumstances described above and at an entry-level of support consistent with the CHSP.

In addition, CHSP providers should only supply additional CHSP services to home care package clients where they have capacity to do so without disadvantaging other current or potential CHSP clients - that is, CHSP services should prioritise people who

need CHSP support but do not have access to other support services over people who are already in receipt of a home care package.

If recommended for CHSP services, the assessor will refer the client to an appropriate CHSP provider, in line with standard My Aged Care referral processes and is advised to set a support plan review date to monitor the services.

### 15.6. Continuity of Support (CoS) Through CHSP

At the time of transition from state-managed specialist disability services to the Commonwealth Continuity of Support (CoS) Programme, providing their needs can continue to be met, eligible clients may choose to have their specialist disability services funded under CHSP instead of the CoS Programme. In this instance, clients will not need to undertake an eligibility assessment under My Aged Care. However, once they become a CHSP client and their needs change, they will be able to have their needs assessed and support services reviewed as needed, through My Aged Care.

Over time, CoS Programme clients may signal an interest in accessing aged care supports instead of the CoS Programme. In this instance, the CoS provider will refer the client to My Aged Care, for screening and assessment for aged care services.

Further information:

The Department of Health website for:

[Commonwealth Home Support Programme](#)

[Resources for CHSP & CHSP Manual effective 1 July 2018](#)

[Living well at home: CHSP Good Practice Guide](#)

[Continuity of support through CHSP](#)

## 16. Home Care

Home care is coordinated care consisting of a package of personal care services and other personal assistance provided to a person who is not being provided with residential care. Under the *Act*, the Australian Government provides a subsidy to an approved provider of home care to coordinate a package of care, services and case management to meet the individual needs of older Australians. The Home Care Packages Program helps older Australians with complex care needs live independently in their own homes. Home care package recipients are not limited to a basic list of services as approved providers work with each of their clients to select services that are tailored to the individual's care needs and goals.

Funding for a home care package now follows the consumer to provide them with greater choice in selecting an approved provider and allow for flexibility to change provider, including if they move to another area to live. The structure of a client's package will be developed by the approved provider working in partnership with the consumer to co-design the package based on the assessed care needs as determined by the ACAT and an individualised budget for their home care package. This provides greater transparency to the consumer about what funding is available under their package and how funds are spent, which ensures greater accountability for the way approved providers manage their home care packages.

A person must be assessed as meeting all the eligibility criteria in order to be approved by an ACAT as eligible to receive home care. Eligibility requirements for Home Care are stated in Part 2.3, Division 21-3 Aged Care Act 1997 and Part 2, Section 7 Approval of Care Recipients Principles 2014. The [ACAT Guidance Framework for Home Care Package Level](#) provides guidance on identifying the client's current needs and determining if those needs are being met, before a recommendation is made. Further detail on assessor and delegate responsibilities relating to home care are being developed in consultation with state and territory health departments.

Further information:

The Department of Health website for:

[Home Care Packages Program](#)

[Home Care Package Delegate Decisions from 27 February 2017](#)

[Assisting clients with their home care package journey](#)

[QRG 13: Management of home care packages from 27 February 2017](#)

[ACAT Guidance Framework for Home Care Package Level](#)

[Information for Assessors: Guidance Documents](#)

The Federal Register of Legislation for:

Definition of Home Care can be found at Part 3.2 Division 45-3 [Aged Care Act 1997](#)

Eligibility requirements for Home Care can be found at Part 2.3, Division 21-3 [Aged Care Act 1997](#) & Part 2, Section 7 [Approval of Care Recipients Principles 2014](#).

[Increasing Choice Consumer Amendment Act 2016](#)

## 17. Residential Care

Residential care can take the form of permanent residential care and residential respite care.

### 17.1. Permanent Residential Care

Permanent residential care is personal care, nursing care, or both, that is provided to a client in a residential facility in which they are also provided with accommodation.

A person must meet all the eligibility criteria in the Act in order to be approved by a delegate as eligible to receive residential care. Eligibility requirements are stated in Section 21-2 of the [Aged Care Act 1997](#) and Part 2, Section 6 of the [Approval of Care Recipients Principles 2014](#).

A person who is eligible for residential care may require daily assistance with:

- meals including special diets
- bathing, showering, dressing and personal hygiene
- toileting and continence management
- organising and taking medication
- communication (including fitting sensory or communication aids)
- transfers and mobility
- assessment and referral for appropriate support
- emotional support.

Where possible, assessors aim to support people to live in the community as long as possible. The Comprehensive Assessment may, however, identify residential care as a suitable option for a client currently living in the community who is no longer able to be adequately cared for by carers or family, even with the full range of community supports in place.

Some clients may have special needs that may be best met by residential aged care facilities which offer particular kinds of care, such as dementia specific facilities. If this is the case, then ACATs should include this information in the record of assessment and the support plan.

Application and approval for residential care means the person meets the eligibility criteria and the care type is appropriate for their care needs. The approval does not compel the client to enter residential care. Decisions about residential care must be done with the consent of the client, and if they do not have capacity, their authorised representative.

When a client is approved for residential care, issuing a referral code is usually the appropriate referral method on My Aged Care. This allows the client, their carers and/or family to identify a residential care home that meets their needs.

Following a client's admission, residential service providers conduct an appraisal using the Aged Care Funding Instrument (ACFI) to determine the level of care to be provided to meet the client's current needs and establish the related Australian Government subsidy.

Further information:

The Department of Health [website](#) for Residential Care

The Federal Register of Legislation for:

Definition of Residential Care Part 3.1, Section 41-3 of the [Aged Care Act 1997](#)

Eligibility requirements Part 2.3, Section 21-2 [Aged Care Act 1997](#)

Part 2, Section 6 of the [Approval of Care Recipients Principles 2014](#)

Care & Services Part 2, Division 1, section 7 of the [Quality of Care Principles 2014](#)

## 17.2. Residential Respite Care

Respite care is provided as an alternative care arrangement with the primary purpose of giving a carer or a care recipient a short-term break from their usual care arrangement. Residential respite is not intended as an alternative to aged care rehabilitation services or restorative care.

To be eligible for respite care, a person must meet the eligibility criteria for residential care.

An approval for residential respite care may be given for either low or high respite. When recommending a client for residential respite, the assessor must determine the level of respite needed to support the client. The approval of a person for a certain level of care (high or low) not only enables the person to receive care at the appropriate level but also regulates the respite subsidy payable to the residential facility.

A person approved for a high level of care is able to access care at a lower level, without the need for reassessment and approval. However, if a person's approval is limited to low level, a reassessment and new approval is required to access a high level of care. A person may be approved for a level of respite care and permanent residential care simultaneously. For example, this might be necessary where the carer has a current need for residential respite and at assessment it is foreseen that the client needs permanent residential care, but there are factors that prevent the client from entering ongoing residential care at that point in time.

A respite care approval entitles the client to a maximum of 63 days of respite care in a financial year, however, extensions may be granted (*see 17.3 below*). The respite days are not required to be taken consecutively. Usage can span across the financial year.

Subsidised respite care cannot be taken in a residential aged care facility if a care recipient is already receiving permanent residential care in an aged care facility.

### 17.3. Residential Respite Care Extensions

A delegate has the power to grant an extension up to 21 days. The 21 day extension is added to the maximum number of days and there is no limit on the number of extensions that may be granted.

Any 21 day extension that is current on 30 June in a given year will cease on that day, as the person automatically becomes eligible for their annual allocation of another 63 days of respite from 1 July each year.

The provider they must submit a respite extension through the provider portal to the ACAT on, or before, 63 days has ended if the person requires further respite care. The ACAT will receive the request through the assessor portal to action. The delegate is able to grant the request if it due to factors such as carer stress or absence of the client's carer, severity of the client's condition or any other relevant matter.

If the form is submitted on or before the end of the respite period (the 63 days or the extension period), the ACAT is still able to approve the form after the respite period has ended and the extension dates will reflect the start date requested in the form.

For clients approved for residential respite care prior to the ACAT transition to the My Aged Care system and do not have a Comprehensive Assessment on My Aged Care, the residential respite extensions can be processed using the [form](#) available through the DHS website.

The extension, if granted, will be at the approved level of care. If a higher-level of care is required, the client must be reassessed and approved by the ACAT for the higher-level of care.

If the request is granted, the provider will be able to claim payment for the respite supplement for the further care provided by up to 21 days. The system will not end date a residential respite extension, to reflect the legislation that the days are not required to be taken consecutively.

The delegate also has the power to reject the request. Where multiple extensions are being requested in one financial year the ACAT should review the support plan in consultation with the client, family and provider, to confirm the appropriateness of the residential respite care with the possibility of considering other care options.



Further information:

Eligibility, Part 2.3, Division 21-2 [Aged Care Act 1997](#) & Chapter 2, Division 3, Sub-division A, Section 23 (2) [Subsidy Principles 2014](#)

[QRG 10 Delegate Processes](#)

[Summary of My Aged Care System Changes - 4 December 2017](#)

[Summary of My Aged Care System Changes - 26 February 2018](#)

The Department of Human Services website [Residential respite extension form AC017](#)

## 18. Flexible Care

Flexible care acknowledges that the needs of aged care recipients may require a different care approach than that provided through mainstream residential and home care. Flexible care can take the form of:

- Transition Care
- Short-Term Restorative Care
- Innovative Care Services
- Multi-Purpose Services.

Further information:

The Department of Health [website](#) for Flexible Care

Definition of Flexible Care, Part 3.3 Section 49-3 [Aged Care Act 1997](#)

### 18.1. Transition Care Programme (TCP)

TCP provides short-term care and services that are therapeutic, goal oriented, and time-limited. The TCP is for clients at the conclusion of a hospital stay who require more time and support in a non-hospital environment to complete their recovery and optimise their functional capacity while assisting them and their family or carer to make long term care arrangements. TCP provides therapeutic care so that clients can maintain and improve their physical, cognitive and psycho-social functioning thereby improving their capacity for independent living.

TCP provides a package of services that includes low intensity therapy (such as physiotherapy, occupational therapy and social work) and either nursing support or personal care. TCP also provides medical support such as GP oversight, case management including establishing community supports, and services and, where required, identification of residential care options.

### Duration of care

The maximum number of days for a transition care period is 84 days. This may be extended to 126 days, if the client has been approved for an extension.

### Lapsing

A transition care approval will lapse:

- if the client does not enter care within the entry period – that is four weeks (28 days) beginning on the day after the date of the delegate's approval
- if the client is not provided transition care, for a period of at least one day after the entry period for the person's approval ends (i.e., if the client stops receiving transition care).

### Transition Care Eligibility and Assessment

A person must meet all the eligibility criteria in order to be approved by an ACAT as eligible to receive transition care. Eligibility requirements are stated in Part 2.3, Section 21-4 [Aged Care Act 1997](#) and Part 2 Section 8 [Approval of Care Recipients Principles 2014](#).

In addition to the eligibility criteria in the Approval of Care Recipient Principles 2014, ACATs will need to consider the following points when assessing eligibility for transition care:

- At the time of assessment, the client must be an in-patient of a hospital, medically stable and ready for discharge.
- As entry to transition care must immediately follow a client's discharge from hospital, the assessment for transition care must only be made in a hospital environment.
- Clients waiting for a residential aged care placement, pending availability, and do not have the capacity to benefit from a further therapeutic care program are not eligible and should not be approved for transition care.
- The ACAT should assess the client in consultation with the hospital geriatric rehabilitation service or equivalent, or members of the treating multidisciplinary team including a registered nurse, physician, occupational therapist, physiotherapist, speech therapist or social worker.
- The ACAT must ensure that the full range of clinical and rehabilitation support to be provided by the hospital has been exhausted before a client enters transition care.
- ACATs should, wherever possible, facilitate liaison between hospital discharge planners and TCP approved providers to ensure that clients are able to access transition care in a timely manner.

### Re-admission to Hospital from Transition Care

The episode ceases if there is a break in care of more than one day, excluding an overnight stay in hospital. If the person is subsequently able to be discharged from hospital within the entry period relevant to their transition care approval, they are able to enter a new transition care episode without the need for an additional transition care approval. The maximum duration of the new transition care episode is 84 days, with the possibility of an extension to 126 days, regardless of the duration of the earlier episode.

### Transition Care Extension

The ACAT is required to assess that a transition care extension is required and to specify the duration of the extension up to 42 days

A transition care service provider is able to submit the extension request through the provider portal to the ACAT on, or before, the 84 days has expired. The ACAT will receive and action the request through the assessor portal. The approved provider should submit the request to the ACAT well in advance of the 84 days ending to allow the ACAT sufficient time to review and consider the request to make a decision.

For the ACAT to assess that the client has further transition care needs, the approved provider is required to provide the following information within the extension request such as:

- reasons why goals were not achieved in 84 days
- physical, cognitive and psychosocial goals that the care recipient would be working on during the extension
- team action required to achieve care recipient goals and discharge
- action required by external services to achieve care recipient goals and discharge
- relevant information from other sources such as the care recipient (or representative) or health professionals
- the proposed number of days of extension.

Based on the information provided by the service provider, and other sources such as the care recipient and relevant health professionals as appropriate, the ACAT needs to be satisfied that the client has further therapeutic care needs and wishes to continue transition care. The delegate will determine whether or not to grant the extension and specifies the number of days of extension (up to 42 days).

In some cases, the ACAT may decide to undertake a reassessment prior to granting the extension or may decide not to extend the transition care period and to conduct a reassessment towards the end of the transition care episode.

While a decision to extend or not extend a care recipient's episode of transition care is not a reviewable decision under the *Act*, the Department will review the decision not to extend the episode of care if a complaint is made (See 20.4).

Further information:

The Department of Health [website](#) for the Transition Care Programme

Definition Transition Care, Chapter 4, Part 1, Div. 3, section 106 [Subsidy Principles 2014](#)

Eligibility requirements Part 2.3, Section 21-4 [Aged Care Act 1997](#) & Part 2 Section 8 [Approval of Care Recipients Principles 2014](#).

Duration of Care; Extensions, Chapter 4, Part 2, Section 111(5) [Subsidy Principles 2014](#)

Entry period and lapsing Part 2.3 Division 23-3 (1) of the [Aged Care Act 1997](#) specified in Part 5, Section 15 & 16 [Approval of Care Recipients Principles 2014](#).

## 18.2. Short-Term Restorative Care (STRC)

STRC is aimed at reversing or slowing functional decline in older people through the provision of a package of care and services designed for, and approved by, the care recipient who is to receive the care and services.

STRC provides care that is multidisciplinary, goal oriented, time-limited and targeted to clients who are experiencing functional decline that could be slowed or reversed. STRC can be provided in a residential care setting, a home care setting or a combination of both.

### Services provided by STRC

STRC provides multidisciplinary care to meet client goals. Each STRC multidisciplinary team must include at least three disciplines. One of these must be a medical practitioner, and where possible this will be the care recipient's GP or geriatrician. The other disciplines forming the multidisciplinary team must be selected to meet the client's needs and may include disciplines such as physiotherapy, occupational therapy and social work. STRC services are designed to slow or reverse the client's functional decline, in turn increasing their capacity for independent living and overall wellbeing.

STRC services can be delivered anywhere within the specified state or territory that a service provider has an allocation of places. STRC providers must give priority of access to clients within the aged care planning region the service provider's places have been allocated to. Prior to referral to an out of region service provider, the service provider should be consulted.

### Duration of care

The maximum number of days for an STRC episode is 56 paid days (eight weeks) however some clients may complete the program in less time. On the client's request to the provider, STRC clients may take up to seven days unpaid leave from the program. Leave days do not need to be consecutive.

### STRC eligibility and assessment

In assessing a person's eligibility for STRC, the ACAT must use the eligibility criteria listed at section 8A of the *Approval of Care Recipients Principles 2014*. The delegate will only approve a person if the person meets all the eligibility criteria for STRC.

A person is eligible to receive STRC only if they meet all of the following criteria:

- the person is assessed as experiencing functional decline that is likely to be reversed or slowed through short-term restorative care
- the person is at risk of losing independence to such a degree that, without short-term restorative care, it is likely that the person will require home care, residential care or flexible care provided through a multi-purpose service
- the person is not receiving residential care, home care through a Commonwealth home care package or flexible care in the form of transition care
- the person is not on leave from a residential care service or a flexible care service through which the person is receiving flexible care in the form of transition care
- the person would not be assessed as eligible to receive flexible care in the form of transition care if the person applied for flexible care in the form of transition care
- the person has not, at any time during the six months before the date of assessment, received flexible care in the form of transition care
- the person has not, at any time during the three months before the date of assessment, been hospitalised for a condition related to the functional decline
- the person is not receiving end of life care and
- in receiving the proposed episode, the person will not have received more than 2 episodes of short-term restorative care in any 12 month period.

When considering STRC services for a client, a number of factors need to be taken into account:

- The intent of STRC is to benefit clients through providing intensive multidisciplinary care designed to slow or reverse identified functional decline before there is a need for hospital, home care or residential care.
- Clients waiting for a residential aged care placement, pending availability, and who do not have the capacity to benefit from an intensive therapeutic care programme are not eligible and should not be approved for STRC.
- STRC is a high value and intensive programme that aims to facilitate independence and delay entry of clients into higher-levels of care. Clients receiving STRC should have a desire to return to prior levels of independence or enhance their ability to undertake the activities of daily living.
- STRC can also be considered as an early intervention for clients who have been assessed as being suitable for a home care package but may benefit from STRC and as a result not require a home care package until a later date or will require a lower level of home care package following an episode of STRC.
- A person may receive STRC whilst also receiving CHSP services and/or the following DVA services:
  - VHC
  - Community Nursing (CN)
  - Rehabilitation Appliances Program (RAP)
  - Attendant care
  - Household services
  - Home modifications
  - Counselling Services (VVCS).

When a client is assessed and approved for STRC, the ACAT should also consider the client's longer-term care needs and recommend services that the client is eligible for that will meet these needs. In some cases, it may be more appropriate to undertake a reassessment towards the end of the STRC episode.

### Lapsing of STRC Approval

An approval for STRC will lapse if:

- the client's episode of STRC ends or
- if the client is not provided STRC, for a period of at least one day after the entry period for the client's approval (which runs for six months from the day after the approval) ends, and the client's care has not been suspended for any of the non-care period (*see Breaks in care below*).

## Breaks in Care

If care has commenced during the entry period, an approval will expire if there is a break in care of more than one day, and the client has not requested a suspension of care. On the client's request to the provider, STRC clients may suspend their care for up to seven days. These "leave days" do not need to be consecutive. If care is suspended for more than seven days, the STRC approval will expire.

Further information:

The Department of Health [website](#) for the Short-Term Restorative Care Programme

Definition STRC Chapter 4, Part 1, Division 3, 106A [Subsidy Principles 2014](#)

Eligibility criteria Part 2-3, Division 21-4(c) [Aged Care Act 1997](#) & Part 2, section 8A of the [Approval of Care Recipients Principles 2014](#)

Conditions Part 2-3, Division 23-3 (1)(a) [Aged Care Act 1997](#) & Part 5, 15 (2) [Approval of Care Recipients Principles 2014](#) ; Chapter 4, Part 2, Division 5, 111A (4) [Subsidy Principles 2014](#)

### 18.3. Multi-Purpose Services

The Multi-Purpose Services (MPS) Program is a joint initiative of the Australian Government and state and territory governments. It aims to deliver flexible and integrated health and aged care services to some small rural and remote communities that could not viably support stand-alone hospitals or aged care homes. The majority of MPS are located in outer regional or remote areas and are co-located with a hospital.

#### Services provided by an MPS

All MPS must deliver residential care and at least one other service, which would generally include acute or sub-acute care, primary care or other health services. Some MPS also deliver flexible care in a community setting.

#### Approval for flexible care provided by an MPS

An ACAT approval is not a legislative requirement for clients to access flexible care in an MPS; however, it is best practice that all older people requiring aged care services are assessed prior to entry. This ensures that the client's aged care needs are assessed and that the most appropriate type and level of aged care services are recommended to meet those needs, which may include flexible care delivered by an MPS. Where an assessor refers a client to an MPS they must record the decision and decision reason in the support plan. ACATs can also record their decision in the approval letter.

Most MPS will request clients have a current ACAT assessment prior to entry, which will also help inform care planning processes. Should the need arise for a client to transfer from an MPS to a residential aged care service; the process will also be streamlined if the client already has an ACAT approval for residential care.

MPS are included in the My Aged Care Service finder and can receive assessment and client information through the provider portal.

Further information: The Department of Health [website](#) for the Multi-Purpose Services Program

#### 18.4. Innovative care

The current range of innovative care services are only available to the existing cohort of clients; that is, at this stage no new clients are eligible to access innovative care services.

Further information: The Department of Health [website](#) for the Innovative Care Programme

### 19. Other

#### 19.1. The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP)

NATSIFACP funds organisations to provide flexible, culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community. These services are mainly located in remote and very remote locations.

##### Services provided by a Flexible Aged Care Service

NATSIFACP services can deliver a mix of residential and community services in accordance with the needs of the community. Services are located mainly in rural and remote areas and not regulated under the *Act*.

Eligibility and approval for care provided by a NATSIFACP Service

People aged 50 years and older who:

- are of Aboriginal and or/ Torres Strait Islander descent
- identify as an Aboriginal and/or Torres Strait Islander or
- are accepted by the community they live in or come from.

Potential care recipients are not required to be assessed and approved by an ACAT. However, a holistic and culturally appropriate assessment by a health professional, RAS or ACAT where possible is best practice and is recommended. If CHSP services or services under the *Act* are not available and the client has aged care needs that could be met through NATSIFACP, the RAS or ACAT can refer the client to these



services, and record the decision and decision reason in the support plan. ACATs can also record this decision in the approval letter.

Further information:

The Department of Health [website](#) for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program

## 19.2. Department of Veterans' Affairs (DVA)

Veterans have the same right of access to other community and aged care programs, as any other member of the community. The *Act* lists veterans in the special needs group. They should not be discriminated against or refused care when accessing services from other community and aged care programs on an assumption that DVA will provide for all their care needs. DVA only provides some entry-level care services. It does not provide higher-level care services.

### Veterans' Home Care (VHC) Program

Veterans' Home Care (VHC) is a DVA program designed to assist veterans and war widows/widowers who need a small amount of practical help to continue living independently in their own home. Services include Domestic Assistance, Personal Care, Respite Care, and safety-related Home and Garden Maintenance. VHC is not designed to meet complex or high-level care needs.

### Community Nursing (CN)

CN provides clinical nursing and/or personal care services to eligible members of the veteran community in their own home. CN services can assist with medication, wound care, hygiene and dressing. CN services can help to restore or maintain health and independence at home and assist to avoid early admittance to hospital or residential care. Veterans requiring high level care require prior approval by DVA.

CN services are provided by a mix of personnel including registered and enrolled nurses and nursing support staff, who work within the framework of their relevant national standards.

### Duplication of services

As long as there is no duplication of services between the programs, Veterans may access DVA's VHC and CN services at the same time as accessing different services from:

- a home care package
- CHSP
- TCP
- STRC.

For home care packages, this access can occur regardless of the level of the package.

CHSP offers services that are not available through the VHC Program or other DVA arrangements, such as a wide range of social support, food services, community transport and centre-based day respite.

Further information:

The Department of Veterans' Affairs [website](#) for [Veterans' Home Care](#) and [Community Nursing](#)

### 19.3. Carer Programs

Assessors should inform carers that there are support services available to assist them in their caring role, including access to emergency or short-term respite, information and advice, financial assistance and counselling.

Assessors should inform carers that information regarding carer support services can be accessed through the Carer Gateway.

The Carer Gateway is a national online and phone service that is dedicated to assisting carers with reliable carer-specific information, resources and advice, and also connects carers with services in their local area.

The website also has a service finder providing carers with the ability to look for particular services that may be in their area.

Carer Gateway is for all carers, no matter what their age is or whom they care for, to access information and advice to help them make informed decisions and get support for their situation.

Carers can call the national contact centre on **1800 422 737** Monday to Friday 8am – 6pm (across all Australian time zones) and speak to an Australian based team.

Carers can also access practical information and resources to help them in their caring role on the Carer Gateway [website](#).

Further information:

Carer Gateway: **1800 422 737** and the Carer Gateway [website](#)

## PART E - COMPLAINTS & REVIEW

### 20. Complaints

#### 20.1. Right to Complain

Clients and or their carer/advocate/family have the right to raise their concerns about the information, service or care they have received from My Aged Care, their assessor or service provider.

There are different ways to make a complaint depending on what part of My Aged Care that the concern relates to such as:

- the contact centre
- Home Support assessment with the RAS
- Comprehensive Assessment with the ACAT
- the outcome of the Comprehensive Assessment
- the care and services received from a service provider.

Further information:

The My Aged Care [website](#) for My Aged Care How to make a complaint

#### 20.2. Concerns about My Aged Care

A person should discuss their concerns about the service or information they receive from My Aged Care with the contact centre in the first instance.

If they are unable to resolve the issue, My Aged Care will provide a reference number to track the progress of the complaint. The person should receive a response within 10 business days.

A person can make a complaint by:

- calling My Aged Care on **1800 200 422**
- lodging an online feedback form on the My Aged Care website at [myagedcare.gov.au/contact-form](http://myagedcare.gov.au/contact-form)
- faxing their complaint to **1800 728 174**

OR

- posting their complaint to:
 

My Aged Care Complaints  
PO Box 210  
Balwyn VIC 3103

If an assessor has a concern with the My Aged Care contact centre they can report their issue to the My Aged Care Provider and Assessor Helpline on **1800 836 799**.

If a client, assessor or provider is not satisfied with the response received, they can take further action by sending an email with the detail of their complaint, and their My Aged Care reference number to: [myagedcaresupport@healthdirect.org.au](mailto:myagedcaresupport@healthdirect.org.au)

### 20.3. Concerns about the Home Support Assessment (RAS)

RAS organisations are required to have complaints procedures in place.

If a person has concerns about their assessment, they are advised to contact the RAS assessor or their organisation in the first instance.

If the person cannot first resolve the issue with their RAS assessor or their organisation, they are advised to call My Aged Care for assistance on **1800 200 422**. Complaints relating to assessment organisations are escalated to the Department for investigation.

### 20.4. Concerns about the Comprehensive Assessment (ACAT)

ACATs are employed by state and territory governments who have complaint handling procedures which should be followed if a complaint has been received.

If a person has concerns about their assessment they are advised to contact their ACAT assessor or manager in the first instance.

If the person cannot first resolve the issue with their ACAT assessor or manager, they are advised to ask the ACAT for the contact details of the state or territory ACAP manager.

Complaints are escalated to the Department if the state or territory procedures do not resolve the complaint.

### 20.5. Complaints about a Provider

- If clients and/or their carer/advocate/family are unhappy with any aspect of the care or services being received from an aged care home, in their own home through a home care package or a CHSP service, or through flexible care services, there are two ways to make a complaint: speak to the service provider about their concerns
- make a complaint to the Aged Care Complaints Commissioner.

In addition to the above, complaints about care received from MPS or TCP can be referred to the relevant state and territory health department complaints bodies.

Please note that complaints related to Australian Government Aged Care policies, guidelines or decisions should be referred to the Department.

Further information:

The My Aged Care [website](#) for the Aged Care Complaints Commissioner

## 21. Right of review (ACAT)

### 21.1. The Right of Review / Reconsideration Process

If a person or someone whose interests are affected by an ACAT delegate decision does not agree with a delegate decision they can contact the ACAT to discuss their concerns in the first instance. A person whose interests are affected includes potential and current care recipients and their immediate families, carers or legal guardians as well as aged care service providers.

The right of review could relate to decisions such as a non-approval, a limitation of the approval to a certain type of aged care, or an approval only for a certain time period.

If the person still has concerns they can ask for a reconsideration of the decision by writing to the Secretary of the Australian Government Department of Health, outlining why they think the decision should be changed:

The Secretary  
 Department of Health  
 Attn: Aged Care Assessment Program  
 GPO Box 9848  
 SYDNEY NSW 2001

The power to reconsider a reviewable decision is delegated by the Secretary to the Department's delegates. A request for reconsideration must be made in writing within 28 days of the date on which the person first received written notice of the decision. However, there is provision for the Department delegate to extend the period for submitting the request.

Once a request has been received, the decision must be reconsidered. The reconsideration will involve a review of the documentation supporting the original decision and may include a reassessment by another ACAT.

### 21.2. Delegate Decisions that are Reviewable

Division 85 of the *Act* deals with the reconsideration and review of decisions following a delegate decision. 'Reviewable decisions' are listed in section 85-1 of the *Act*. Of these, ten decisions relate to the approval or non-approval of people as care recipients, as shown in Table 4. The ACAT delegate has the power to make seven of these decisions (Items 19, 20, 21, 22, 23, 25A, 25B). The Department delegate can make all the decisions in the table, including those decisions in blue.

**Table 4 Reviewable decisions approval of care recipient**

Item	Decision	Provision under which decision is made
19	To reject an application to approve a person as a care recipient	subsection 22-1(2)
20	To limit a person's approval as a care recipient	subsection 22-2(1)
21	To limit a person's approval as a care recipient to one or more levels of care	subsection 22-2(3)
22	To vary a limitation on a person's approval as a care recipient	subsection 22-2(4)
23	As to when a person urgently needed care and when it was practicable to apply for approval	paragraph 22-5(2)(b)
24	To extend the period during which an application for approval as a care recipient can be made	subsection 22-5(3)
25	To reject an application to extend the period during which an application for approval as a care recipient can be made	subsection 22-5(3)
25A	To determine a person's priority for home care services	subsection 22-2A(1)
25B	To vary a person's priority for home care services	subsection 22-2A(2)
26	To revoke an approval of a person as a care recipient	subsection 23-4(1)

Further information: Reviewable decisions: Part 6.1, Division 85-1 of the [Aged Care Act 1997](#)

### 21.3. The Role of ACATs in the Reconsideration Process

As part of the request for reconsideration, the Department delegate may discuss the request with the ACAT assessor and delegate to clarify matters relating to the case.

If required, the Department's delegate may request that an independent ACAT reassess the client. The independent reassessment is usually done by an ACAT that was not involved in the original decision. The ACAT undertaking the reassessment can consult the original assessors and delegate, and as many relevant parties as required to ensure all necessary information required of the Department delegate is collected.

There are some points to note about a reconsideration review:

- The Application for Care form is not signed by the client, however the informed consent of the client to the reassessment is still required and must be obtained prior to undertaking the reassessment.
- Through the ACAP manager in the state or territory, the Department delegate will request in writing the information the ACAT needs to collect and how it is to be recorded. Depending upon the request, it may be necessary to use the NSAF (accessible from the assessor portal) or other form as specified by the Department delegate.
- The reassessment includes comprehensive information and recommendations, including any recommendations about limitations on approvals for the client.
- The assessor does not discuss the reassessment with the applicant, the client or any other party in any way after completing the reassessment.

### 21.4. Advice on the Outcome of the Reconsideration (ACATs)

A determination is usually made within 90 days. When the determination is made the Department delegate will write to the person who has sought the reconsideration to let them know the outcome of the review, and give reasons for the decision. Where appropriate, the Department delegate will also advise any other relevant parties of the outcome.

The notice of the reconsideration decision includes additional information on further review rights available to the applicant.

The reconsideration decision is usually recorded on My Aged Care to be effective from the date of the original ACAT delegate decision that is being reconsidered.

### 21.5. Administrative Appeals Tribunal (AAT)

If the person who has requested a reconsideration of a decision is dissatisfied with the outcome, an application may be made to the AAT for a review of the decision. There is a cost to the applicant for this process.

ACATs must ensure that all information used in making approval decisions, including information gathered to support reviews of reviewable decisions is properly maintained and available for review by the AAT, if necessary.

The Department delegate and the ACAT delegate who made the original decision may be required to appear before the AAT.

Further information: The AAT [website](#)

### 21.6. Ombudsman

The Commonwealth Ombudsman's role is to review the actions and decisions of Australian Government agencies. The Ombudsman's office handles complaints, conducts investigations, performs audits and inspections, and carries out specialist oversight tasks to see if the actions and decisions of agencies are wrong, unjust, unlawful, discriminatory or unfair.

Clients, and/or their carer/advocate/family can contact the Commonwealth Ombudsman through their website.

Further information: The Commonwealth Ombudsman [website](#)



## PART F - FEES AND PAYMENTS

It is important that aged care clients understand the potential costs of care early in their interaction with the aged care system.

Assessors are not responsible for providing detailed financial information about the fees or charges that a person may be charged to access aged care services, but assessors have a role in advising clients about where they can access the information they need and what the process may entail. They should be able to assist clients in access to appropriate support should there be financial disadvantage (See 22.5 Financial Hardship).

Ideally, clients should be referred to the My Aged Care website and the contact centre for information regarding care costs and fees prior to the face-to-face assessment. This gives the client time to consider the information prior to the assessment.

### 22. Aged Care Program Fees

#### 22.1. Fees for CHSP

A client does not need a financial assessment to access CHSP services.

Under the CHSP, the Client Contribution Framework (the Framework) outlines the principles service providers can adopt in setting and implementing their own client contribution policy with a view to ensuring that those who can afford to contribute to the cost of their care do so, whilst protecting those most vulnerable. Under this framework client contributions should not exceed the actual cost of service provision.

During an assessment a RAS assessor is required to explain to a client that they are expected to contribute toward the costs of the CHSP services they receive, if they can afford to do so.

Each service provider is required to have their own client contribution policy to determine the amount of fees. Clients are expected to discuss client contributions with their service provider before commencement of these services, after they have been assessed by a RAS.

Where a CoS client transitions to CHSP they will not need to pay any more for their current services under the CHSP than they have been paying for their current specialist disability services. For example, if the client does not pay fees now, then they will not pay fees under CHSP.

Further information: The Department of Health [website](#) for the CHSP Program Manual and [CHSP Manual effective 1 July 2018](#)

## 22.2. Fees for Home Care Consumers

For home care consumers, an income test determines the person's contribution to their care, known as an 'income-tested care fee'. Full pensioners will not be asked to pay an income-tested care fee.

DHS will have the income information of anyone in receipt of a means tested income support payment, and will be able to determine the income-tested care fee (if any) without the person completing an income assessment form.

Where a person is not in receipt of a means tested income support payment and does not complete an income assessment form, their income-tested care fee will be set at the maximum per day rate at the second cap. The second cap is the daily cap applying on income tested care fees where the consumer's income exceeds the income threshold. Information about the current rates of fees and charges is available on the [Schedule of Fees and Charges for Post-1 July 2014 Residents](#).

Even where a person does not need to complete the form, he or she may wish to complete it prior to entry to receive an indication of the fees that will be payable.

Providers do not need to wait for an income assessment to be completed before a consumer can commence a home care package. However, providers maintain their own individual admissions policies. Some providers may require the income assessment to be completed prior to a consumer being offered a home care package. There is nothing in the *Act* which prevents a provider from setting this requirement.

Rather than try and make a judgment as to whether a person needs to complete the income assessment form, the ACAT should leave a form with the prospective home care consumer and suggest they seek further advice. The form and information booklet gives the person information, including a contact number at the Department, to request fee advice.

Further information:

The Department of Health [website](#) for Home care fees for consumers entering a home care package from 1 July 2014

The My Aged Care [website](#) for Help at home costs

The Department of Human Services [website](#) for Aged Care Fees Income Assessment form (SA456)

## 22.3. Clients Entering Permanent Residential Care

If a person is interested in taking up permanent residential care or home care, the process is simpler if a combined income and asset assessment has been completed prior to the commencement of care.

A combined income and asset assessment made before entering care is valid for 120 days unless there is a significant change in the person's circumstances.

For care recipients entering permanent residential care from 1 July 2014, a combined income and asset assessment is required to determine the person's contribution to their care costs, and whether the person is eligible to receive government assistance with their accommodation costs.

Residential care recipients who receive a means tested income support payment from Centrelink and who are recorded as being a non-homeowner for age pension purposes do not need to complete the combined income and asset assessment form.

Given this is a small cohort of people, it is reasonable to expect that most prospective care recipients should complete the form.

Even where a person does not need to complete the form, he or she may wish to complete it prior to entry to receive an indication of the fees that will be payable.

Where a care recipient entering permanent residential care from 1 July 2014, who is not in the category above, elects not to complete the income and assets assessment form, they will be liable to pay the full cost of their care, until they reach the annual cap, and pay the accommodation price agreed with the aged care provider.

Providers do not need to wait for a combined income and asset assessment to be completed before a consumer can be admitted to residential care. However, providers maintain their own individual admissions policies. Some providers may require the combined income and assets assessment to be completed prior to the care recipient being admitted. There is nothing in the *Act* which prevents a provider from setting this requirement.

#### 22.4. Interim Fees Pending Income and Assets Assessment

A provider may choose to charge an interim fee while waiting on the results of the assessment. However, the Government does not set an amount of interim fee. Once DHS has advised of the fees payable any overpayment would need to be refunded.

Where the care recipient is already known to DHS and all the required income and asset information is available already, a simple assessment is usually completed within 24-48 hours.

More complex assessments or where further information is required from the care recipient, can take up to four weeks to complete from the time the application is lodged.

DHS is also producing letters on demand where they become aware of an urgent requirement for an assessment to be progressed.

Further information:

The Department of Health [website](#) for Residential care fees for residents who enter care from 1 July 2014

My Aged Care [website](#) for Aged care homes accommodation costs

The Department of Human Services (DHS) [website](#) for Permanent Residential Aged Care - Request for a Combined Assets and Income Assessment form (SA457)

## 22.5. Financial Hardship

A client may also be eligible to apply for financial hardship assistance with:

- Home Care (post 1 July 2014 only):
  - basic daily care fee: and/or
  - income-tested care fee
  
- Residential Care:
  - basic daily fee and/or
  - income tested fee (pre-1 July 2014) and/or
  - means-tested care fee (post-1 July 2014) and/or
  - accommodation costs.

If a person is granted financial hardship, the Australian Government will pay some or all of their aged care costs. The amount payable by the person will be reduced by the amount paid by the Australian Government, including nil payment. Each case is assessed on an individual basis, taking into consideration a range of issues that may be unique to the resident.

To apply for financial hardship assistance, the client or their representative will need to complete an application for financial hardship assistance and submit the form to the DHS. A copy of this form and associated guidelines can be found on the DHS website (see below).

Further information:

The Department of Health website for [Hardship Supplement in Home Care](#) and [Hardship Supplement in Residential Care](#)

The My Aged Care [website](#) for financial hardship assistance

The Department of Human Services website for [financial hardship assistance for Home Care and Residential Respite Care form \(SA462\)](#) and [financial hardship assistance for Residential Aged Care form \(SA461\)](#)

## 22.6. Fees for Flexible Care Programs (STRC and TCP)

STRC and transition care service providers may charge clients a daily care fee.

The care fee that clients may be charged for both programs is calculated on a daily basis for every day the client receives care.

For care delivered in a residential care setting, the maximum value of the care fee is 85% of the basic daily rate of the single basic age pension.

For care delivered in the home, the maximum care fee is 17.5% of the basic daily rate of the single basic age pension.

The above rules on maximum fees apply to both single and married clients.

Further information:

The Department of Health [website](#) for Section 4-6 of the Transition Care Programme Guidelines

The Department of Health [website](#) for Section 3.10 Short-Term Restorative Care Programme Manual

The Federal Register of Legislation [website](#) Part 3A, Division 2 Section 23AB - User Rights Principles 2014

## 22.7. Fees for DVA Clients

DVA will pay the fees for home care packages, CHSP, TCP and STRC veterans who are Australian former Prisoners of War or Victoria Cross recipients.

Further information:

The Department of Veterans' Affairs [website](#) Factsheet HSV10 - Financial Support for Former Prisoners of War and Victoria Cross Recipients Accessing Aged Care Services

## 22.8. Non-Australian Residents

The CHSP does not have any exclusion from services based on citizenship, residency status or eligibility for Medicare support.

Non-Australian residents are not excluded from entitlements under the *Act* and Visa holders do not require a Medicare Card in order to access an ACAT assessment.

Under the *Act*, non-Australian residents may also be eligible for Government assistance with their aged care costs, if the person has been approved by an ACAT and has had their income (for home care) or income and assets (for residential care) assessed by DHS. This will ultimately depend on the circumstances under which the person has come to Australia under the *Migration Act 1958* as their visa conditions may require them to give an assurance of support to repay their aged care and/or medical costs.

While the Australian Government is the majority funder of aged care, beyond this support it is expected that people will use their income and/or assets, depending on their care type, to contribute to the costs of their care, where they can afford to do so. The amount that the person can be asked to contribute will be assessed by DHS under the same rules as any other aged care recipient. Similarly, the basic daily fee payable for residential care by the person cannot be more than 85 per cent of the single rate of the basic age pension, irrespective of whether or not the person receives the age pension. The same applies for home care, but the basic daily fee is 17.5%.

The Department of Home Affairs should be contacted in relation to this matter if an assurance of support has been given.

Further information:

The Department of Home Affairs [website](#)

## PART G – OPERATIONAL PROCEDURES

### 23. Record Keeping of Information

#### 23.1. Collection and Protection

Assessors collect information about clients and their families as part of the assessment and approval process and are required to comply with the legislative requirements under the [Privacy Act 1988](#) which regulates the handling of personal information about individuals, including the collection, use, storage and disclosure of personal information, and access to and correction of that information (See *Section 5.1 Privacy legislation*).

Any information collected for the purpose of assessing recipients for the provision of Commonwealth-subsidised aged care is collected on behalf of the Commonwealth and is therefore Commonwealth property. This includes client notes or any other material and documents created for the purpose of preparing the client record.

The *Act* has further provisions to protect this information that applies to ACATs. Personal information as defined under the *Act* means information or an opinion (including information or an opinion forming part of a database), whether true or not, and whether recorded in a material form or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion.

It is critical that assessment organisations have systems, protocols and processes in place to ensure the safety of client records from loss, interference, damage, misuse, unauthorised access, modification or disclosure. This requirement relates to APP 11. Penalties may apply to agencies and individuals for breaches to the *Privacy Act*. Assessment organisations must refer to the Office of the Australian Information Commissioner website for more instruction on the handling of personal information and the handling and consequences of misuse.

If a record of an assessment is a state or territory government record as well as being a Commonwealth record, there may be further requirements to retain and store the information under local legislation. Assessment organisations should seek advice from their state or territory government on any local requirements and meet all the requirements set by both levels of government.

#### 23.2. Storage and Retention

The *Archives Act 1983* (the *Archives Act*) governs the record keeping procedures for Australian Government agencies. Agencies must also comply with any directions issued by the National Archives of Australia (NAA). The Records Authority no 2011/00396196 specifies this as seven years for “records, including case files, relating to the recipients of residential care, community care, or flexible care services” and

three years for records documenting “handling routine public enquiries about the core business of aged and community care”.

As the Records Authority is made under a law of the Commonwealth, its requirements relating to the recording and retention of documents can be met by electronic means as provided by section 12 of the *Electronic Transaction Act 1999* (*Electronic Transactions Act*). Section 12 (2) allows retention of paper forms into electronic forms. For example, scan of the hard copy (including signed forms) and store the documents electronically as part of the client’s record. Section 12(4) further provides for electronic communications in certain circumstances are required to be retained for a specified period, to be retained in an electronic form. The *Electronic Transactions Act* refers to maintaining the integrity of a document or information contained in a document, if the information has remained complete and unaltered apart from addition of any endorsement or any immaterial change which arises in the normal course of communication, storage or display.

### 23.3. Use

Assessors and other staff must be aware that information they acquire in the course of their work that is personal information may not be recorded or disclosed or otherwise used apart from the purpose for which it is collected and that the person consents (See Section 5.3 Consent). For instance, clients may not be discussed with the staff member’s family or friends in any way that would allow a client to be identified, written records of ‘interesting cases’ may not be kept by staff members, and cases may not be referenced in public discussion such as in a Letter to the Editor or in social media. There are some exceptions under the *Act* noted under Section 23.5 ‘Exceptions to general prohibitions’ below.

Any systems developed for the collection and analysis of data should incorporate adequate procedures to protect the privacy of people being assessed. If data is to be used for purposes other than assessment, or individual care planning, assessors must have procedures in place to ensure that client confidentiality is maintained and individuals cannot be identified.

### 23.4. Release

Assessors must ensure that they only release information for which they have appropriate authority to release. In cases where there is any doubt about the release of information, the assessor should discuss this situation with the organisation manager. The manager may further consult the assessment organisation’s auspice organisation, the state or territory government, the Department or obtain independent legal advice if any doubt remains, before releasing information.



### 23.5. Aged Care Act 1997 exceptions

The *Act* provides for very specific exceptions to the general prohibition on the use of information under 86-2 Use of protected information (2). This includes allowing ACATs:

- To use protected information to carry out their functions and duties and to exercise their delegated powers (if they are delegates) under the *Act*.
- To disclose information only to the person to whom it relates (i.e.; about the client only to the client, and information about a family member only to the family member). Assessors should note that this subsection does not allow them to disclose information about the client to a family member.
- To use protected information in ways that have been authorised by the person to whom the information relates. If the client has given permission, this subsection allows the ACAT to disclose information about the client to a family member. If a family member has given permission, it also allows the ACAT to disclose information about the family member to the client.
- To remove any potential conflict between the *Act* and any other legislation which may authorise some other use of information that is protected under the *Act*.

In relation to the use of information, there are criminal penalties associated with committing an offence as established under Section 86-2 (1). If a person charged with an offence under Section 86-2 (1) wishes to use an exemption in Subsection 86-2 (2), the defendant has the obligation to show there is sufficient evidence that they were entitled to rely on one of the exemptions.

All staff should exercise extreme caution in handling the personal information of aged care clients.

#### [Additional exceptions for people conducting assessments](#)

Section 86-4 of the *Act* allows some further exceptions for ACAT staff from the general prohibition on the use of protected information when conducting assessments. This includes any information relating to a person for the purposes of the provision, assessing the needs, reporting on, conducting research into, the level of need of and access to aged care, or other community, health or social services.

### 23.6. Destruction

The destruction of paper records must be by secure waste bins, through a T4 accredited waste management agency. Further information about T4 accreditation is available on the Australian Security Intelligence Organisation (ASIO) website. Assessment organisations must also maintain a means of identifying what has been destroyed, and be able to produce evidence if requested by the Department.

The destruction of electronic records requires the deletion of all copies of the record from any system in such a way that it is impossible to restore the record. This

destruction should also be included in the means that identifies what has been destroyed.

Further information:

The Office of the Australian Information Commissioner [website](#) for the *Privacy Act* and *Principles*

The Federal Register of Legislation for Chapter 6, Part 6.2, Section 86-2 Use of protected information [Aged Care Act 1997](#); the [Archives Act 1983](#) and Part 2, Division 2, Retention Section 12 [Electronic Transaction Act 1999](#)

The National Archives of Australia [website](#) for Records Authority 2011/00396196

The ASIO [website](#) ASIO T4 Protective Security

## 24. Freedom of Information

The Commonwealth *Freedom of Information Act 1982 (the FOI Act)* gives members of the public rights of access to official documents of the Commonwealth and its agencies. The *FOI Act* extends, as far as possible, the right of the Australian community to access information (generally documents) in the possession of the Commonwealth, limited only by considerations of the protection of essential public interest and of the private and business affairs of persons in respect of whom information is collected and held by departments and public authorities.

Further information:

The Federal Register of Legislation for the [Freedom of Information Act 1982](#)

## 25. Branding

Assessment organisations that are contracted to or in an agreement with the Australian Government under the oversight of the Department are required to comply with branding guidance that is included in the following style guides:

- Aged Care Assessment Programme (ACAP) style guide
- My Aged Care - Regional Assessment style guide.

ACATs are required to direct any enquiries about branding to their relevant state or territory authority for further information and resources. RAS subcontractors are required to consult with their prime contractor on branding requests.

## 26. Training

The My Aged Care training requirements are set out in the My Aged Care Assessment Workforce Training Strategy (the Strategy) which defines and sets the minimum training requirement for the My Aged Care Assessment Workforce, including timeframes for completion.

My Aged Care assessment organisation contract managers have access to the Strategy however the Strategy can be provided upon request by emailing [myagedcare.training@health.gov.au](mailto:myagedcare.training@health.gov.au)

### Summary of current My Aged Care assessor training

The Department requires all Home Support Assessors within the RAS to undertake the:

- My Aged Care Statement of Attainment 2 – Home Support Assessor and
- National Screening and Assessment Form (NSAF) and Systems Training and
- Self-Paced Learning Experiences for Working with Aboriginal and Torres Strait Islander People, Working with Culturally and Linguistically Diverse People and Working with Carers and the Care Relationship and
- Organisational specific induction training.

The Department requires all Comprehensive Assessors within ACATs to undertake the:

- My Aged Care Statement of Attainment 3 – Comprehensive Assessor and
- National Screening and Assessment Form (NSAF) and Systems Training and
- Self-Paced Learning Experiences for Working with Aboriginal and Torres Strait Islander People, Working with Culturally and Linguistically Diverse People and Working with Carers and the Care Relationship and
- Organisational specific induction training.

Delegates are also required to complete the My Aged Care ACAT Delegation Training.

From time to time the Department may require assessors to undertake additional training when changes are made to programs, policies or processes.

Further information:

The Department of Health [website](#) for the ACAP National Training Strategy

## 27. Reporting and Performance

Assessment organisations are expected to meet KPIs and other measures on timeliness and performance according to their agreements with the Commonwealth. Assessors hold a high level of responsibility in facilitating timely access to aged care assessments. The Department monitors these aspects of assessment through performance measures that include:

- The detail of timeliness measures in Section 8.2 Priority for Referrals.
- 95% of ACAT assessments are expected to be completed within 75 days.

See the KPI diagrams for RAS and ACATs at Appendix 4 and 5.

### Table 5 My Aged Care assessment reports

The following reports are currently available to RAS and ACAT accessed through the My Aged Care assessment portal.

Report ID	Report ID & Name
Bespoke	<p><b><u>ACATS Outstanding Assessment report by Jurisdiction</u></b></p> <p>Provided to each jurisdictional ACAP manager at the end of each month to advise on their numbers of open assessment that are greater than 75 days for the month.</p>
MYAC001	<p><b><u>RAS KPIs report</u></b></p> <p>Allows the Department and RAS organisations to track performance against contractual KPIs that:</p> <ul style="list-style-type: none"> <li>• 90% of Referrals for Assessment to the outlet are accepted by that outlet.</li> <li>• 90% of Referrals received from the Gateway System are actioned (either accepted or rejected) by the outlet within 3 calendar days.</li> </ul>
MYAC002	<p><b><u>RAS Assessments Completed with Timeframes Report</u></b></p> <p>Allows the Department and RAS organisations to track the performance of RAS Assessment Referrals to ensure they are actioned within KPI Timeframes.</p>
MYAC003	<p><b><u>ACAT KPI Adherence Report</u></b></p> <p>Allows the Department and ACAT Assessor Organisations to track performance against contractual KPIs that:</p> <ul style="list-style-type: none"> <li>• Assessment Referrals are actioned within KPI Timeframes.</li> <li>• Clinical Interventions occur within KPI Timeframes.</li> </ul>
MYAC004	<p><b><u>ACAT Timeframes for Individual Assessments Report</u></b></p> <p>Allows the Department and ACAT organisations to track performance against contractual KPIs to ensure Assessment Referrals are actioned within KPI Timeframes.</p>

Report ID	Report ID & Name
<b>MYAC005</b>	<p><b><u>ACAT Assessment Referrals Breakdown Report</u></b></p> <p>This report assists an ACAT organisation to manage their workload of incoming and outstanding referrals for assessment at the organisation and outlet levels. It also allows the Department of Health staff to monitor the performance of various Assessment Organisations across the States and Territories.</p> <p>The report provides a breakdown of referrals for assessment issued, accepted (by high, medium and low priority), recalled, transferred, rejected and actioned during the time period selected.</p>
<b>MYAC006</b>	<p><b><u>RAS Assessment Referrals Breakdown report</u></b></p> <p>This report helps a RAS organisation to manage their workload of incoming and outstanding referrals for assessment at the organisation and outlet levels. It also allows the Department of Health staff to monitor the performance of various Assessment Organisations across the States and Territories.</p> <p>The report provides a breakdown of referrals for assessment issued, accepted (by high, medium and low priority), recalled, transferred, rejected and actioned during the time period selected.</p>
<b>MYAC007</b>	<p><b><u>RAS KPI Adherence report</u></b></p> <p>This report enables RAS organisations to check on their performance against five key performance indicators (KPIs) at the overall organisation level or for one or more of their Outlets:</p> <ul style="list-style-type: none"> <li>• 90% of referrals for assessment are actioned within 3 Calendar days</li> <li>• 90% of referrals for assessment are accepted by the contractor</li> <li>• High Priority RAS assessments, completed within 10 Calendar days of acceptance</li> <li>• Medium Priority RAS assessments, completed within 14 Calendar days of acceptance</li> <li>• Low Priority RAS assessments, completed within 21 Calendar days of acceptance</li> </ul> <p>In addition this report provides a detailed listing of all the referral and assessment details for a selected organisation or outlet via a drill-through functionality which could be exported to an excel spreadsheet.</p>

Report ID	Report ID & Name
MYAC008	<p><b><u>ACAT Comprehensive Assessments &amp; Approvals report</u></b></p> <p>This report enables ACAT organisations to review amount of delegated assessments completed for a selected period and associated aged care related service approvals provided under various categories: These include:</p> <ul style="list-style-type: none"> <li>• Residential Respite (High/Medium/Low)</li> <li>• Home Care Packages (Level 1/2/3/4)</li> <li>• Flexible Care (Transitional, Short-Term Restorative)</li> <li>• Emergency Care</li> <li>• Extension to existing Care</li> <li>• No Care under the Act</li> </ul> <p>In addition this report summarises the amount approvals under all categories.</p>
MYAC009	<p><b><u>ACAT Comprehensive Assessment Referral Trend Report</u></b></p> <p>This report assists an ACAT organisation to view the weekly or monthly trend of assessment referrals on various stages at the organisation or outlet levels. It also allows the Department of Health staff to monitor the performance of various Assessment Organisations across the States and Territories.</p> <p>The report provides separate referral trends for issued, accepted, recalled, transferred, rejected, finalised and non-actioned during the time period selected. In a selected period, if a referral is first accepted and subsequently if the same referral is rejected in the same period, it's counted and included in the trend of both accepted and rejected stages.</p> <p>Basically, this report provides a graphical trend of referral activities as they happened for a given Organisation/outlet for a selected time period. Optionally, this report may be narrowed down to a selected (High, Medium, Low) priority level.</p>
MYAC010	<p><b><u>RAS Home Support Assessment Referral Trend Report</u></b></p> <p>This report assists a RAS organisation to view the weekly or monthly trend of assessment referrals on various stages at the organisation or outlet levels. It also allows the Department of Health staff to monitor the performance of various Assessment Organisations across the States and Territories.</p> <p>The report provides separate referral trends for issued, accepted, recalled, transferred, rejected, finalised and non-actioned during the time period selected. In a selected period, if a referral is first accepted and subsequently rejected in the same period, it's counted and included in the trend of both accepted and rejected stages.</p> <p>Basically, this report provides a graphical trend of referral activities as they happened for a given Organisation/outlet for a selected time period. Optionally, this report may be narrowed down to a selected (High, Medium, Low) priority level.</p>

Report ID	Report ID & Name
MYAC012	<p><b><u>RAS Reasons for Ending Home Support Assessments</u></b></p> <p>This Report provides reasons for ending RAS assessments by outlet and by specific reason with a defined period.</p>
MYAC013	<p><b><u>ACAT Reasons for Ending Comprehensive Assessments</u></b></p> <p>This Report provides reasons for ending ACAT assessments by outlet and by specific reason with a defined period</p>
MYAC014	<p><b><u>ACAT Recommended Long Term Living Environments</u></b></p> <p>This report provides an analysis of the Long Term Living Environment Recommendations for Comprehensive Assessments completed during a selected period. This should assist an ACAT organisation to monitor and manage its assessment results at the state &amp; outlet levels. It also helps Department of Health staff to monitor the performance of various ACAT organisations.</p>
MYAC015	<p><b><u>Demand of Services for Service Providers</u></b></p> <p>This report provides an analysis Services Referrals generated for various Service Provider Organisations as a result of various assessments. This allows a Service Provider organisation to monitor the number of service referrals received by them over a selected period. This report is a crosstab between</p> <ol style="list-style-type: none"> <li>1. Outlet / Service Referral Status on X-axis</li> <li>2. Aged Care Programme / Service / Subtype</li> </ol>
MYAC016	<p><b><u>RAS Home Support Assessment Stage Timeframes report</u></b></p> <p>This report enables the Department of Health to monitor durations between key home support assessment milestones across RAS organisations. It allows drill through to the outlet-level durations of the selected RAS organisation. For external users the report is limited to the outlets' data their access privileges cover.</p>
MYAC017	<p><b><u>RAS Business Allocation report</u></b></p> <p>This report provides the percentage of Home Support Assessment referrals issued to a particular outlet with a given funding region, by month for a financial year.</p> <p>Background: As part of the contractual agreement between the Health department and Regional Assessment Service organisations, an agreed percentage of assessment referrals will be allocated to a given outlet with a specified funding region each financial year.</p>

## APPENDIX 1 - NATIONAL ASSESSMENT FRAMEWORK

The purpose of the National Assessment Framework (the Framework) is to ensure a nationally consistent approach to assessing people's aged care needs and eligibility for government-funded services. The Framework provides assurance that the aged care assessment workforce, funded by the Australian Government to conduct the processes involved in assessing a person's aged care needs, is supported appropriately, and that reporting requirements by and for organisations and government are enabled. Governance arrangements support its implementation and delivery. **Table 6** below includes the Framework components and sub-components.

Component	Sub--component
<b>Workforce</b>	Contact centre staff in the My Aged Care contact centre My Aged Care Regional Assessment Service Aged Care Assessment Teams
<b>Funding</b>	Commonwealth funding to operate the Workforce
<b>Processes</b>	Nationally consistent assessments Complaints Compliance Quality Assurance
<b>Support</b>	ICT platform that operationalises My Aged Care, including the Assessor Portal User Guides (NSAF User Guide, Assessor Portal User Guide) Aged Care Assessment Quality Framework My Aged Care Assessment Workforce Training Strategy Departmental Administration
<b>Reporting</b>	Mandatory reporting Business reporting Organisation reporting
<b>Governance</b>	Legislation The <i>Aged Care Act 1997</i> (the Act) Workforce contracts and agreements Internal governance within the Department focussing on operational control, policy, clinical guidance and engagement with other government agencies External governance including with consumers, stakeholders and peak bodies Engagement with delivery partners



## APPENDIX 2 - THE AGED CARE ACT 1997 AND THE AGED CARE PRINCIPLES

The *Act* is the legislative basis for the Australian system of aged care. Commonwealth-subsidised aged care is provided under the *Act* as either residential, home care, or flexible care.

The *Act* also enables the Minister to make Principles required or permitted under the *Act*, or necessary or convenient to carry out or give effect to Parts or sections of the *Act* (see section 96-1 of the *Act*).

The Manual includes content from the *Act* and the Principles. The *Act* and the Principles can be amended by the Parliament and the Minister respectively. Current versions of the *Act* and the Principles can be accessed at the Federal Register of Legislation [website](#).

The *Act* is available under “Acts” and is simply called the *Aged Care Act 1997*. The *Aged Care Principles* are available under “Legislative Instruments” or can be searched for by name. They can only be accessed under their individual names.

Further information:

The Federal Register of Legislation website for a full list of the Principles Chapter 7, Division 96-1 of the [Aged Care Act 1997](#)

## APPENDIX 3 - REASSESSMENT (ACAT)

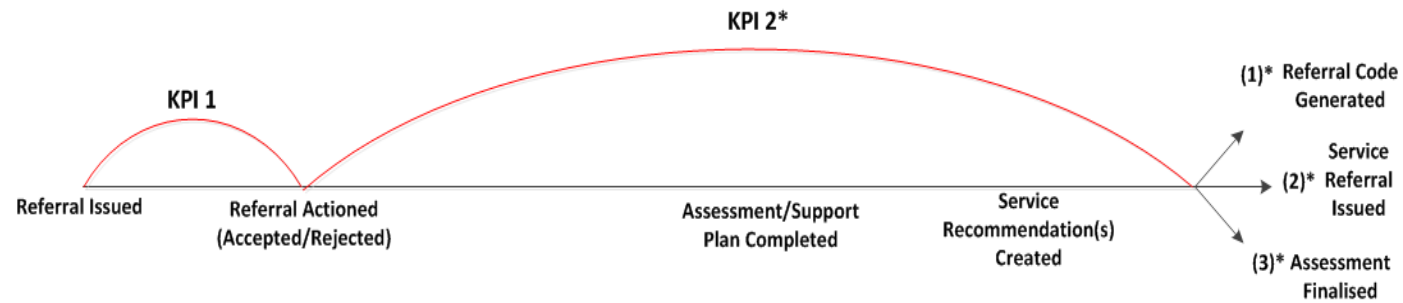
While an assessor should always check whether a reassessment is required for unusual cases, Table 7 is a resource to guide when a reassessment is required by an ACAT on or after 1 July 2009 for approvals by an ACAT that are not time-limited. Also disregard any periods when the person is on leave under the Act. For approvals prior to 1 July 2009, please seek advice from your state or territory ACAT manager.

ACAT Approval	Is reassessment required?	Changes to legislation
<b>High level residential care</b>	<b>No</b> – for approvals dated on or after 1 July 2009.	Lapsing of approval for high level residential care was removed on 1 July 2009. On 1 July 2014 approval for low and high levels of care was removed and care type became permanent residential care which does not lapse. From 20 March 2008, a person's approval for residential care did not lapse if they left a residential care service and re-entered care within 28 days.
<b>Low level residential care</b>	<b>Yes</b> – if approved on or before 30 June 2013 and the person did not enter care within 12 months of the approval.  <b>Yes</b> – for approvals dated on or before 30 June 2013: if there was a break in care for more than 28 days between 20 March 2008 and 1 July 2014, and after the 12 month entry period had ended.	On 1 July 2014 approval for low and high levels of care was removed and care type became permanent residential care which does not lapse. Prior to 1 July 2014, section 23-3(1) of the Aged Care Act provided that an approval lapsed if the person did not enter care within 12 months. From 20 March 2008, a person's approval for residential care did not lapse if they left a residential care service and re-entered care within 28 days.
<b>Permanent Residential care</b>	<b>No</b> – this care type does not lapse.	This care type was introduced on 1 July 2014 to replace approval for levels of care in permanent residential care (high and low). Since 1 July 2014, this does not lapse.
<b>High level residential respite care</b>	<b>No</b> – for approvals dated on or after 1 July 2009.	Lapsing of approval for respite care (at any level) was removed on 1 July 2009.
<b>Low level residential respite care</b>	<b>No</b> – for approvals dated on or after 1 July 2009. <b>Yes</b> – if there has been a change to the person's care needs and they need a	Lapsing of approval for respite care was removed on 1 July 2009.

ACAT Approval	Is reassessment required?	Changes to legislation
	higher level of care. <b>Yes</b> – if approved on or before 30 June 2008 and the person did not enter care within 12 months of the approval.	
<b>Home Care Level 1 or 2 or 3 or 4</b>	<b>Yes</b> – if there has been a change to the person’s care needs and they need a higher level of care.	Home Care for Level 1 and 2 was introduced on 1 August 2013 and replaced Community Aged Care Packages (CACPs) Home Care for Level 3 and 4 was introduced on 1 August 2013 and replaced Extended Aged Care at Home (EACH) and Extended Aged Care at Home – Dementia (EACH-D) Removal of broad banding for home care was introduced 27 February 2017. A person who was eligible for Levels 1-2 home care was taken to be eligible for level 2, and a person who was eligible for levels 3-4 home care was taken to be eligible for level 4.
<b>Home Care Priority</b>	<b>Yes</b> – if the person’s care needs warrant a change. The Secretary may vary the person’s priority for home care services at any time under section 22-2A.	Home Care priority was introduced 27 February 2017
<b>CACP</b>	<b>Yes</b> – if approved on or before 31 July 2012 and the person did not commence receiving care within 12 months of the approval.	This care type was replaced by Home Care on 1 August 2013
<b>EACH and EACH-D</b>	<b>No</b> – for all approvals for EACH and EACH-D dated in 2009 or later.	Lapsing of approval for EACH and EACH-D was removed on 1 January 2009. This care type was replaced by Home Care on 1 August 2013
<b>Transition Care</b>	<b>No</b> – if the client enters hospital from transition care for longer than an overnight stay, concludes their hospital episode and re-enters transition care (from hospital) within the 4 week entry period. <b>Yes</b> – if care is not provided within 4 weeks from the day after the approval date. <b>Yes</b> – if there is a break in care of at least one day after the 4 week entry period. <b>Yes</b> – an ACAT assessment may be necessary if the transition care episode	

ACAT Approval	Is reassessment required?	Changes to legislation
	<p>is to be extended. A transition care episode may be extended from 84 days up to a maximum of 126 days. An ACAT reassessment may be needed if the delegate is not satisfied with the information about the care recipient's further transition care needs supplied by the service provider in the extension request.</p>	
<b>STRC</b>	<p><b>Yes</b> – if the client is not provided with STRC within six months from the day after the approval date.</p> <p><b>Yes</b> – if there is a break in care of at least one day (excluding a suspension of care, provided care has not been suspended for more than seven days during the episode) after care commences.</p> <p><b>Yes</b> – if the client commences another type of care under the Act (residential, flexible or home care).</p> <p><b>Yes</b> – if the short-term restorative care episode ends.</p>	<p>The <i>Aged Care Act 1997</i> (the Act), and its subordinate legislation (<i>Approval of Care Recipients Principles 2014, Subsidy Principles 2014</i>) provide the legislative framework for the administration and delivery of the STRC Programme.</p>
<b>Flexible care in an MPS (multi-purpose service) or Innovative Care</b>	<p>A person does not need to be approved to receive care in an MPS or innovative care service. However, the person might happen to be approved for residential care or home care.</p> <p>If a person wishes to leave the MPS/innovative care service to enter a mainstream residential care service or to begin receiving home care, the ACAT will need to check whether there is an existing approval and determine whether a new approval is needed.</p>	<p>Under the <i>Subsidy Principles 2014</i> the following persons do not need approval for flexible care: people who receive flexible care through an MPS, and people who receive flexible care through an innovative care service.</p>

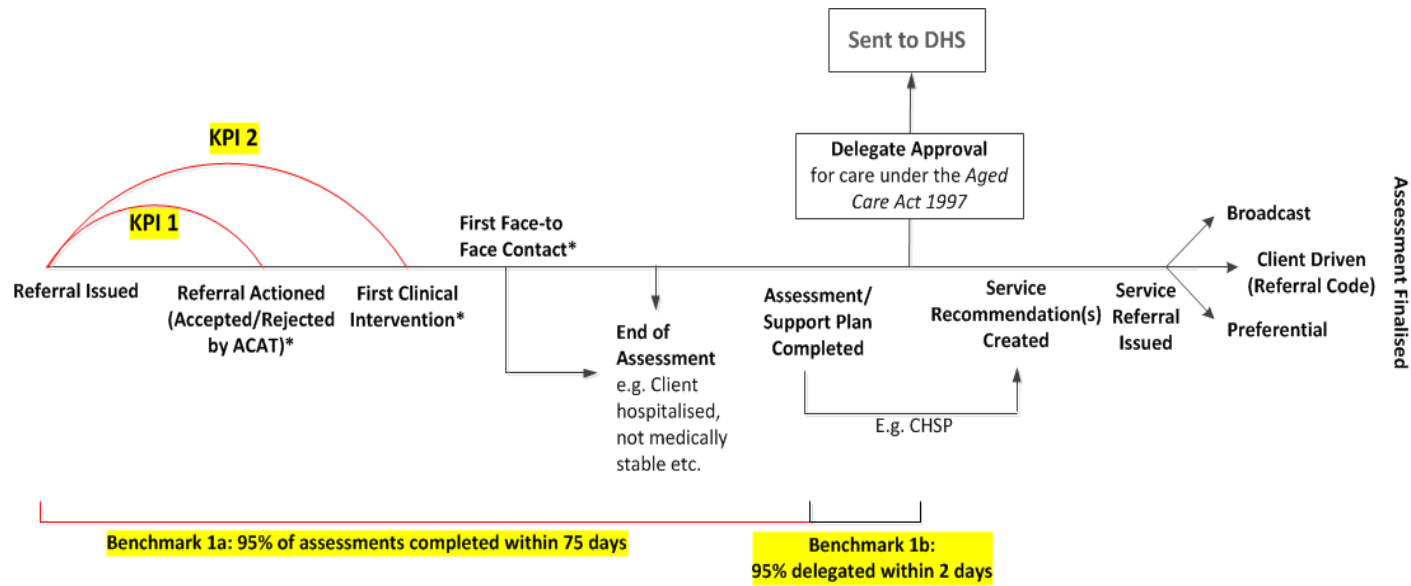
## APPENDIX 4 – RAS KPIs



\*A RAS assessment will be deemed to have reached the end point for the Timeliness KPI calculation when at least of the following conditions is met:

1. The assessment status is 'Assessment Complete' AND at least one referral code has been generated; OR
2. The assessment status is 'Assessment Complete' AND at least one service referral has been issued; OR
3. The assessment status is 'Finalised'

## APPENDIX 5 - ACAT KPIs



\*The Assessment Referral Actioned date, First Clinical Intervention date and First Face to Face date are often the same date.

## APPENDIX 6 - CONTACT DETAILS

Please contact your manager in the first instance for all queries and/or issues.

### Carer Gateway

☎ 1800 422 737

### My Aged Care Contact Centre

☎ 1800 200 422

### My Aged Care Provider and Assessor Helpline

☎ 1800 836 799

### My Aged Care complaints

A person can make a complaint by:

- calling My Aged Care on **1800 200 422**
- lodging an online feedback form on the My Aged Care website at [myagedcare.gov.au/contact-form](http://myagedcare.gov.au/contact-form)
- faxing your complaint to **1800 728 174**

OR

- posting their complaint to:

My Aged Care Complaints  
PO Box 210  
Balwyn VIC 3103

### ACAT Right of Review a person can write to:

The Secretary  
Department of Health  
Attn: Aged Care Assessment Programme  
GPO Box 9848  
SYDNEY NSW 2001