Care Coordinator, Access to Care Program (Suffolk County, NY)

The Care Coordinator (CC) is responsible for providing care coordination for clients' support system within or outside of the Health Home network. The Care Coordinator advocates for all clients to obtain the full range of needed services and ensures coordination of such services through the delivery of core services at least monthly. The CC promotes linkage development and monitors the effectiveness of linkages with other service providers through active case conferencing. The CC ensures community outreach and engagement to retain the client in care, promotes client compliance with medical appointments, and encourages client self-sufficiency and empowerment. The CC leads the care coordination conducted by other members of the team, provides leadership and guidance for the team and is responsible for ensuring that the documentation and billing records of ALL team members are complete and up to date.

Responsibilities

- Conducts initial and ongoing assessments of assigned clients to document strengths, needs, goals, and resources within Health Home timelines.
- Ensure all client contacts, home visits and back up documentation are completed in a timely manner according to program standards.
- Lead care coordination team activities.
- Screen clients for Health Home eligibility.
- Plan and evaluate service plans and monitor objectives in a consistent manner. Write progress notes daily; enter into the electronic medical records management system in a timely manner in accordance with Health Home standards.
- Perform home visits according to client needs.
- Educate client and family on health and human service resources, assist in obtaining services, and follow-up on service delivery on a weekly basis.
- Assist client with completing applications and/or letter writing on a regular basis.
- Maintains effective communication with service providers, family, and collateral resources in a professional manner while advocating for clients' special needs.
- Assist clients with problem-solving activities.
- Appropriately intervene in situations requiring immediate attention (i.e. crisis planning and intervention) to ensure safety of clients and family.
- Maintain at least the minimum billing standards for the Health Home (i.e. perform 1 core service per month as necessary)
- Serves as a member of a Care Coordination team, including interacting frequently with the members of the team to ensure coordinated activities; attending and participating in team meetings to provide feedback/input regarding client status, update plans and goals, review outcomes to further program goals.
- Conducts client outreach and engagement while in the field.
- Must use own vehicle to travel to meet clients.

Qualifications and Requirements

- Bachelor's degree in healthcare or human services and at least one year of qualifying experience* or an alternative combination of education, credentials, and experience.
- Bilingual preferred (English/Spanish speaking).
- A valid driver's license and safe driving record are required.
- Must maintain valid First Aid/CPR certification.

*QUALIFYING EXPERIENCE: verifiable full or part-time case management or case work with persons with HIV, AIDS, mental illness, homelessness, chemical dependence, chronic illnesses, or other populations of persons in need.

Work Schedule:

Monday through Friday, 35 hours per week.
8:00 am – 4:00 pm,
8:30 am – 4:30 pm, *or*
9:00 am – 5:00 pm

Benefits

Full Time Employees are eligible for:

- Medical, Dental, and Vision Insurance
- Tuition Assistance
- Flexible Spending Account
- Long-term and Short-term Disability
- Supplemental Specified Illness Coverage
- Supplemental Hospitalization Coverage
- Life Insurance
- 4 Personal Days, 10-22 Vacation Days, 8 Sick Days, 10 Paid Holidays-yearly
- 403(b) retirement plan with employer match

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