



## **JOB DESCRIPTION**

<b>CLASSIFICATIONS:</b>	<b>Case Management/Care Transitions – Licensed Social Worker</b>
<b>FLSA STATUS:</b>	<b>Full-Time/Exempt</b>
<b>REPORTS TO:</b>	<b>Director, Plan 4 Home</b>
<b>QUALIFICATIONS:</b>	<b>Licensed Independent Social Worker (LISW), or Licensed Social Worker (LSW) with unencumbered Ohio licensure required.</b>

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### **JOB SUMMARY:**

This position provides evaluation, outreach, supportive and educational services to clients. The Case Manager (CM) performs all related duties such as making full use of agency and outside resources on behalf of the program participant. The social worker (SW) in the Case Manager (CM) position also monitors, coordinates, manages, and documents the quality and appropriateness of services provided by sub-contractors. Duties include but are not limited to all appropriate aspects of Case Management as provided by the Guidelines of the Case Management Society of America, 2016. The SW Case Manager will undertake activities necessary to promote the achievement of person-centered outcomes within the scope of practice for the Social Worker (SW) as required by the Ohio Board of CSWMFT (Counselor, Social Work, and Marriage & Family Therapy.)

All tasks and functions will be delegated and supervised by the department manager/director.

### **ESSENTIAL FUNCTIONS:**

- Consults with supervising Care Transitions department manager regarding the development of service authorizations and participant plans of care.
- Performs and documents telephone and in-person interviews to identify biopsychosocial needs of participants as they relate to the participant's current functional status and the level of formal/informal support required for person-centered, culturally, and linguistically competent care transitions.
- Refers all program participants and their families to community-based home health and social services utilizing appropriate community resources as they are needed and desired.
- Refers Plan 4 Home or Care Transitions program participants to long-term case management as appropriate and as a participant is willing to transition.
- Determines participant eligibility, ability, and necessity to participate in person-centered, culturally & linguistically competent program service as directed by the program case manager.
- Ensures accuracy and completeness of all required and any other relevant documentation as needed under the guidelines of the program and/or agency.
- Consults with the Director of Medical Education regarding medication reconciliation.

- Assists with the development and implementation of program policies and procedures.
- Establishes type and frequency of services, inclusive of case management visits, assessment, and re-assessments.
- Develops and monitors care and case plans to ensure quality, culturally & linguistically competent care by telephone and in person.
- Contacts with the participant and/or caregiver as appropriate via scheduled home and telephone contacts
- Consistently maintains an effective record-keeping system
- Timely documentation of all interactions with the participant, caregiver, other health service providers within 24 hours of occurrence.
- Timely documentation of care/case or service plans and associated changes within 24 hours of occurrence.
- Prepares and reviews internal and external reports as directed by the department manager
- Coordinates person-centered and culturally & linguistically necessary and desired services through approved program service providers, identifying and resolving service delivery issues as needed.
- Actively participates in program development and evaluation; helps to develop quality improvement monitors, and participates in utilization review, quality assurance, and quality improvement activities as requested.
- Guides participants and their families/caregivers to assist them in the resolution of biopsychosocial and access to HCBS as necessary and desired.
- Provides educational presentations to the public and professional community as necessary
- Maintains current licensure and completes the continuing education requirements of the respective profession and licensing board.
- Participates in monthly departmental team meetings and agency trainings as requested by department manager/director/supervisor
- Other duties as assigned
- May include associated clerical responsibilities

#### **OTHER FUNCTIONS:**

- Opens cases and performs case functions as assigned or directed.
- Coordinate community services as indicated or directed.
- Distributes client satisfaction surveys
- Participates in case conferences with service providers, partner organizations, and families.
- Participates on various committees as directed or assigned by the program supervisor/department manager.
- Maintains confidentiality of participants/families/caregivers and participates in related agency HIPAA training.



- Confer regularly with department manager regarding clinical practice issues, concerns, and program procedures.
- Demonstrates understanding and knowledge regarding issues of cultural and linguistic competency as it relates to the case management of participants in care transition programming
- Engages in culturally and linguistically competent interactions with all program participants and families served by the Care Transitions program and Area Office on Aging agency staff, colleagues, and other agency partners.
- Adheres to Agency policies and procedures.
- Other functions as may be assigned

**ACCESS TO CASE RECORDS:** Access to most participant records.

**QUALIFICATIONS:**

- Licensed Independent Social Worker (LISW), or Licensed Social Worker (LSW) with unencumbered Ohio licensure required.
- One or more years prior experience in home health care, case management, human services, social work, behavioral health services, or related fields.
- Excellent interviewing, verbal, and writing skills; ability to establish rapport and maintain empathetic relationships.
- Experience in conducting health/social interviews; knowledge of human behavior, family/caregiver dynamics, awareness of community resources and services.
- Excellent organizational, planning, time management, and researching skills are necessary.
- Willingness and ability to work independently and as a member of a professional team.
- Knowledge of Microsoft Word and Excel.
- Willingness to engage in personal and professional growth behaviors.
- Bending, lifting, stooping and carrying objects up to 20 pounds.
- Local and overnight travel may be required.
- Maintain reliable transportation, insurance, valid driver's license, and the ability to satisfactorily undergo a Motor Vehicle Record check (MVR) on at least an annual basis.
- Successfully pass an agency-required drug screen and fingerprint criminal background check.
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**AUTHORITY AND RELATIONSHIPS:**

This position reports directly to the Plan4Home Director. This position has no supervisory authority.

**SPECIAL REQUIREMENTS AND CONDITIONS:**

This position shall be terminated if funding sources are not available for AOoA's Long Term Care programs and services department. This position requires criminal background checks, required website

checks, MVR checks, drug/alcohol screening. Such background checks may be repeated as per Agency policy during the employment term.

*This description is intended to indicate the kinds of tasks and levels of work difficulty that will be required for the position. This description shall not be construed as declaring the specific tasks and responsibilities. It is not intended to limit, or in any way modify the rights of any supervisor to assign, direct, and control the work of employees under supervision. The use of this particular expression or illustration describing duties shall not be held to exclude other duties not mentioned that are of a similar kind or level of difficulty.*

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