**Job Title:** **Social Care Navigator**

**Responsible to**: 211 Contact Center Manager with support from Deputy Director

**Job Summary:** The Social Care Navigator will contribute to the implementation of the Southern Tier Region's Social Care Network as part of the New York Health Equity Reform Program Medicaid Waiver Amendment. The Social Care Network is a group of community-based organizations, healthcare providers, and other partners who are working together to provide screening, navigation, and delivery of health-related social needs services to Medicaid Members (Medicaid beneficiaries). The Human Services Coalition is one of the organizations that is participating in the network. Major activities of the Social Care Network include screening Medicaid Members for their social care needs; conducting social care navigation, including eligibility assessment and referral to supportive programs; and providing certain enhanced services to meet individuals' needs. Enhanced services in the Social Care Network include a range of services related to housing, food and nutrition, transportation, and care management.

This position will support the Human Services Coalition's role in the Social Care Network by focusing on the screening and navigation activities. This position will screen Medicaid Members to identify their social care needs using a standardized screening tool, then carry out eligibility assessments to confirm Members' eligibility for the Social Care Network. Depending on eligibility and need, Members may be referred to Social Care Network programs or to other local, state, and federal programs.

The Social Care Navigator will collaborate with other Human Services Coalition staff, including 211 Tompkins/Cortland Helpline specialists, housing specialists, transportation specialists, and health insurance navigators or community health advocates. This position will also engage with other Social Care Network providers as well as the Social Care Network regional lead organization, Care Compass Collaborative.

**Position:** $24.00 per hour. Non-exempt, full-time, 37.5 hours per week. Competitive benefits package including a cafeteria benefits plan and paid time off. Consistent with the Human Services Coalition's Hybrid Work Policy, a flexible, hybrid schedule (in-office and remote) may be possible. Some in-office hours are required. Remote work requires access to high-speed internet and router.

**Duties and Responsibilities:**

*Screening and Social Care Navigation*

- Receive Medicaid Member referrals or direct inquiries, establishing connection and rapport with clientele. Within the framework of the Social Care Network, gain an understanding of client needs and how to support them, depending on eligibility and services available.
- Conduct social care screenings of Medicaid Members using the standardized Accountable Health Communities screening tool. Record results of the screening in the Social Care Network data platform.
- Conduct eligibility assessments of Medicaid Members to determine if they qualify for enhanced services through the Social Care Network. Eligibility assessment may include gathering information from the Medicaid Member, from Medicaid Managed Care Organizations, from healthcare providers, or from other sources.
- Navigate individuals who are eligible for enhanced Social Care Network services related to housing, food and nutrition, transportation, or care management to appropriate services using the Social Care

Network data platform. Refer to non-Social Care Network services (existing local, state, and federal programs and services) as appropriate.
- Navigate individuals who are not eligible for enhanced services to non-Social Care Network services (existing local, state, and federal programs and services) as appropriate.
- Throughout the screening and navigation process, serve as a helpful, supportive, and nonjudgmental resource for Medicaid Members
- Create, update, and maintain Member Care Plans for individuals supported by the Social Care Network.
- Assist in implementation of anonymous, unbiased follow-up survey for clients.

*Social Care Network Participation*
- Become familiar with the Social Care Network program and the available enhanced service types related to housing, food and nutrition, transportation, and care management. Become comfortable with the Social Care Network operations manual, fee schedule, and other guidance documents to ensure appropriate service delivery.
- Gain an understanding the of the local and regional service providers that are participating in the Social Care Network, especially those serving Tompkins County. Develop connections with providers to be able to provide accurate and unbiased information to Medicaid Members. Participate in local or regional Social Care Network events as appropriate.
- Become familiar with and follow the Social Care Network conflict of interest mitigation guidelines.
- Conduct outreach or share information about the Social Care Network to help encourage Medicaid Member participation.

*Data Management/Administrative*
- Participate in Social Care Network training through the regional Social Care Network lead organization, Care Compass Collaborative. Training includes use of the Social Care Network data platform (Unite Us), Social Care Network workflows, and other topics as required.
- Participate in Community Service Specialist training through the 211 Contact Center, including use of the 211 database of resources (through the online platform iCarol), the information and referral process/standards, and use of multiple communication mediums (calls, text messages, internet chat, email, in person).
- Thoroughly log all client interactions in Unite Us, iCarol, and/or other systems as required.
- Keep accurate and complete work files, including records, documentation, and other materials. Maintain organized records of client interactions, referrals provided, and follow-up activities.
- Track progress toward completion of project deliverables as defined by funding contracts.
- Participate in Human Services Coalition activities and planning, including organization-wide and 211 program-specific tasks, and other duties as assigned.

**Qualifications:**
- Strong verbal communication skills and comfort with communicating in person and by phone, email, text message, and other mediums.
- Ability to keep written case notes and submit required documentation.
- Attention to detail and ability to understand and follow complex program guidelines and requirements.
- Comfort with computers and web-based systems. Familiarity with databases, Microsoft Office, and Google Apps a plus.
- Knowledge of (preferred) or interest in learning the human services network in Tompkins County and regionally.
- Self-directed and able to work well independently as well as part of a team.
- Creative thinking, sharing ideas that will help ensure project success.
- Demonstration of a helpful, positive, and nonjudgmental approach, showing respect and fairness for each client and for all stakeholders.