|  |  |
| --- | --- |
| Job Title: | **East Lead SSVF Health Care Navigator & Housing Resource Specialist** |
| Department: | **Community Services** |
| Reports to: | **Homeless Programs Supervisor** |
| Grade: | **DS 13** |
| Supervises: | **N/A** |
| FLSA Status: | **Non-Exempt** |
| Prepared by: | **Sarah Hughes** |
| Date: | **March 25, 2021** |
|  |
| Purpose: The East Lead SSVF Health Care Navigator (HCN) and Housing Resource Specialist will work in partnership with the VA Medical Center as well as the applicable Continuum of Care to administer SSVF offered through NMCAA through the 14 Eastern counties (Alcona, Alpena, Charlevoix, Cheboygan, Crawford, Emmet, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon.) The HCN works closely with the Veteran’s assigned team of specialists and case management personnel to provide veteran centered equitable care. The SSVF worker will act as a leader in the community advocating for an end to veteran homelessness.  |
| **Essential functions:** * East and West SSVF Lead Health Care Navigators will collaborate to create a local network of Veteran and non-Veteran health care service agencies; while developing a referral process and community format that will ensure that all homeless veterans who need health care navigation will have access to the correct services and supports.
* SSVF Health Care Navigators will develop program policies and procedures for administering the health care navigation services.
* Attend SSVF Health Care Navigation Trainings and share new information, policies, and procedures with SSVF team members.
* East and West SSVF Lead Health Care Navigators will collaborate to form an outline of a client’s interdisciplinary team and the key members that should be included for the purposes and benefit of the client during health care navigation.
* Conduct assessments of the Veteran along with the interdisciplinary treatment team to obtain an overall understanding of potential barriers to care, the causes, and the impact of such barriers on the Veteran’s ability to access and maintain health care services.
* Provide strength based, client-centered case management to veterans and their families. The housing case management may include development of a crisis plan, a guest policy, budgeting, rental payment assistance, linkage and referral to other applicable community resources and supports, as well as housing related goal development along with their medical treatment plan and needs assessment.
* The SSVF Health Care Navigator and Housing Resource Specialist will work closely with veterans to assist them in communicating their preferences in care, personal health-related goals to facilitate shared decision making of the Veteran’s care and create a strength-based housing plan that will work to stabilize the individual or families housing situation.
* The SSVF case manager serves as a resource for education and support for Veterans and families while helping to identify appropriate and credible resources tailored to the needs and wishes of the veteran.
* The client’s plan will be developed in collaboration with their interdisciplinary treatment team and the case manager will regularly review the care plan goals with the Veteran, conducts regular non-clinical barrier assessments, and provides resources and referrals needed to support adherence.
* Periodically evaluates the effectiveness of the resources and referrals provided and makes appropriate modifications to ensure the provision of high-quality care and intervention.
* The Health Care Navigator and Housing Resource Specialist assist clients with information on locating and filling out rental applications for suitable housing.
* While assisting clients in maintaining their permanent housing the SSVF Health Care Navigator and Housing Case manager will maintain comprehensive documentation and provide information to the treatment team when appropriate.
* Provide financial assistance to eligible clients through the NMCAA Homeless Prevention programs to clients such as: SSVF, Emergency Solutions Grant, HCV with Homeless Preference and DHS-Disabled Families PSH program. The HRS will learn program guidelines and follow them appropriately to keep in compliance with the grant.
* Complete a Service Prioritization Decision Assistance Tool (SPDAT) for all clients they are working with and use it in developing a housing plan and retaining permanent housing.
* Placing eligible veterans and their families on the MSDHA Housing Choice Voucher waiting list with homeless preference and connecting them to the VASH voucher program. SSVF HRS to additionally complete 120-day recertification for applicable clients within the MSHDA HCV applicant portal.
* Help coordinate supportive and additional services with the Veteran. The incumbent ensures and links Veterans and caregivers to supportive service which include, but are not limited to housing, financial benefits, and transportation.
* Collaborate with other providers and the Continuum of care in the ongoing reassessment of the Veteran’s health care and housing needs.
* The Health Care Navigator and Housing Case Manager can act as an advocate for the Veteran integrating the Veteran’s cultural values into their care plan and identifying methods to monitor their health goals as ongoing follow.
* Complete a Homeless Management Information System (HMIS) profile and maintain clients’ information into the system. Complete information in real time, as they meet and work with their clients.
* Performs other related duties as required and/or assigned.
* Conduct on-going outreach for the SSVF program to identify clients at risk and ensure all veterans can promote self-care and prevent disease. Navigate Veterans and families to the appropriate interdisciplinary team member for identified health education needs.
* Attend any/all area meeting and collaborative efforts to address veteran needs, while adhering to the ethical principles about confidentiality, informed consent, compliance with relevant laws and agency policies (e.g. critical incident reporting, HIPPA, Duty to Warn).
* Develop a local network of Veteran service agencies (Veteran Service Team) and develop a by-name list that will ensure that all homeless veterans will be housed and given the opportunity for entry into the SSVF program or other community services.
 |
| Position Objectives: * To perform the essential functions effectively and efficiently for the betterment of NMCAA and our communities.
 |
| **Measured by:** * Annual performance reviews
* Annual ROMA reports
* Ongoing assessment
 |
| **Minimum Education:** * Master’s level Social Worker or equivalent education and experience is preferred.
 |
| **Minimum Experience:*** At least 2 years’ preferred experience working in a human service/medical related field.
 |
| **Essential Abilities:*** A commitment to the NMCAA philosophy and mission.
* Ability to maintain confidentiality.
* Ability to interact positively with co-workers and clients in a non-judgmental, tactful and courteous manner.
* Ability to suggest innovative approaches in completing job responsibilities.
* Ability to work openly and cooperatively as a team member.
* Ability to perform physical tasks to carry out specific job duties.
* Ability to effectively communicate (written and verbal) with clients, staff and management.
* Ability to carry out all required functions to meet annual program goals.
 |
| **Minimum Skills Required:*** Strong communication skills including, listening, verbal, and written communications.
* Strong organizational skills.
* Excellent report building skills to establish or maintain community partnerships with other organizations.
 |
| **Minimum Physical Expectations:*** Be able to drive and travel as needed.
* Physical activity that often requires extensive time working on a computer, involving keyboarding, sitting, and phone work.
 |
| **Minimum Environmental Expectations:*** The SSVF Health Care Navigator and Housing Case Manager operates in an office setting. This position routinely uses standard office equipment such as computers, phones, photocopiers, filing cabinets, and fax machines.
 |