**People Assisting the Homeless (PATH)**

**CARE NAVIGATOR**

**Summary:**

Care Navigator will assist clients in breaking the cycle of homelessness by transitioning clients from street to housing, and accessing and maintaining necessary services among health care and social services through a coordinated system, acting as Lead Case Manager at Connections Housing Downtown San Diego, where this position will be stationed. Care Navigator will provide individualized client support throughout this entire journey by helping each client develop a plan to address barriers, support health needs, increase income, and maintain and sustain housing. As part of the plan, the Care Navigator will identify each area in which clients will need assistance to accomplish the outlined goals and objectives (i.e. scheduling appointments, applying for public benefits, etc.) and the Care Navigator will focus on housing and health as necessary outcomes for success.

**RESPONSIBILITIES:**

**SUPPORTIVE SERVICES**

* Coordinate intake and individualized needs assessment for all clients and work with clients to develop Individualized Service Plans (ISP) that address barriers to obtaining services/housing and appropriate health care needs.
* Create relationships and systems that strategically coordinate efforts to engage and retain individuals in care that meet their complex needs and ensure adherence to treatment.
* Assist clients in obtaining ID, Birth Certificate, Social Security Income, Disability, etc.
* Provide information, referrals, linkages, and advocacy to assist clients in accessing services and resources
* Monitor and evaluate each client’s progression through their Individual Service Plan (ISP), and develop corrective action revisions to the plan as needed
* Assist clients with housing applications, complete supportive and subsidized housing paperwork, survey rental market for affordable housing, and advocate for clients with prospective landlords; Identify appropriate permanent housing options for clients

**CONTRACT MANAGEMENT**

* Gain proficient knowledge of Multiply Diagnosed HIV Positive Homeless Populations
* Maintain client related data tracking systems, including case notes and complete HMIS entries
* Prepare case-related reports including but not limited to: outcomes, successes and challenges
* JOB DESCRIPTION (continued) Care Navigator
* *P.A.T.H is an Equal Opportunity Employer* Care Navigator Page 2 of 2 Rev 11/2012
* Generate client data for reporting
* Maintain complete and accurate documentation of service objectives and outcomes as well as other services in accordance with Federal, State, County and PATH guidelines
* Complete follow-up and retention services, as necessary, and provide back-up documentation in client file

**OUTREACH AND RELATIONSHIP MANAGEMENT**

* Outreach to community based organizations, housing resources, and service providers to identify new and existing opportunities and build strong relationships to better assist clients in accessing resources, supportive services, health care and benefits, and housing opportunities
* Mediate disputes between homeless persons and neighborhood residents, as needed
* Attend collaborative meetings, as assigned by supervisor
* Network with other agencies, coalitions, and local community meetings
* Actively participate in staff meetings and trainings
* ***Other duties as assigned***

**QUALIFICATIONS**

* Possesses a minimum of an Associate’s Degree, Bachelor’s Degree preferred or equivalent experience in a related field.
* Have at least two years in Case Management experience.
* Project a professional demeanor and interpersonal skills
* Able to work independently and as part the team and exercises mature judgment
* Strong written and verbal communication skills.
* Must have knowledge of maintaining and executing confidential information.
* A highly motivated self-starter and ability to coordinate multiple projects/task
* Ability to work with diverse communities
* Good problem solving and conflict resolution skills.
* Computer skills with proficiency in Microsoft Office software, HMIS training a plus
* Motivated self-starter, with proven ability to develop creative solutions.
* Strong planning and organizing skills
* Flexible, adaptable and have the capability to work in a fast paced, professional environment.
* Maintain regular attendance.

*This publication is part of a series of manuals that describe models of care that are included in the HRSA SPNS Initiative* Building a Medical Home for HIV Homeless Populations*. Learn more at* <http://cahpp.org/project/medheart/models-of-care>