**Attachment A: SPNS Navigator and SPNS Housing Case Manager Job Descriptions**

**SPNS Network Navigator (1.0 FTE)**

**Scope of Work:**

The SPNS Network Navigator works with the staff and management of Cascade AIDS Project (CAP) to provide high-quality, coordinated, strengths-based social services consistent with the agency’s mission; this position is embedded at the Multnomah County HIV Health Services Center (HHSC). The individual assists People Living with HIV/AIDS (PLWHA) who are experiencing homelessness or are at risk of homelessness and have mental health and/or substance abuse disorders. The individual will work across agencies and systems to assure access to services through CAP and HHSC as well as through other social services providers.

Responsibilities include: collaborating with medical case managers, medical teams and other support services providers in developing individual goal plans and providing intensive, community-based support to clients in carrying out the activities to achieve their goals; developing a comprehensive knowledge of the HIV continuum of care as well as non-HIV specific services available in the Portland metro area; educating service providers outside of the HIV continuum of care about HIV and HIV-specific services; outreach and education to people experiencing homelessness about the availability of HIV testing and services; completing forms and entering data into the HHSC and CAP databases in a timely and accurate manner. The Client Network Navigator works collaboratively and communicates effectively with clients, volunteers, CAP and HHSC staff, and community partners.

The person in this position is sited at the Multnomah County HHSC clinic in downtown Portland and will travel throughout the six-county service area for meetings and client home-visits. Evening and weekend work is required. This is a non-management, union-represented position.

**Minimum Qualifications:**

* Bachelor’s Degree in human/social services field (social work, public or community health, psychology) or at least two years of related experience
* Demonstrated computer and keyboard proficiency using Microsoft Office software (Word, Excel, Outlook) and working knowledge of the internet
* Excellent written and oral communication skills
* Successful experience working with ethnic, racial, economic and sexually diverse populations and persons who have experienced homelessness, persons with a mental illness and/or substance addiction
* Demonstrated ability to effectively collaborate with community stakeholders
* Excellent organizational and time management skills
* Ability to work independently with accountability
* Available to work occasional evenings and weekends

**Preferred Qualifications:**

* Previous professional or volunteer experience working with people living with HIV
* Knowledge of social services in the Portland Metro Area
* Knowledge of benefits programs available to people with HIV
* Verbal and written fluency in English and Spanish
* Familiarity with Critical Time Intervention, Assertive Community Treatment or Intensive Case Management models of service

**Essential Job Functions:**

* 1. Develop and maintain collaborative professional relationships with agencies that serve people living with HIV/AIDS; provide mental health; substance abuse; and psychosocial support services.
	2. Work collaboratively with medical case managers, CAP housing case managers, and other service providers to develop individual client goal plans and provide intensive support to clients in carrying out their goal plan.
	3. Attend medical team huddles and semi-monthly case consult meetings with the Multnomah County HHSC staff; some workdays will begin at 8:00 AM to accommodate the HHSC standing meeting schedule.
	4. Assess clients’ involvement in HIV services, identify barriers to care and readiness to access care, including: client knowledge of HIV status, coping resources, social support, substance use and mental health issues.
	5. Establish rapport with clients and work with them to facilitate engagement and retention in medical care and other services that support engagement in care.
	6. Accompany clients to appointments to facilitate access to medical care, substance abuse treatment, mental health services, housing and other needed services.
	7. Collect, maintain and distribute updated information about mental health, substance abuse treatment, psychosocial support and HIV specific services available in the community.
	8. Maintain a strong working knowledge of HIV medical treatment and the progression of HIV disease.
	9. Design and produce written materials in support of the program either as an individual or as a member of the team.
	10. Meet all contract requirements and provide supporting documentation, including program performance data and reports, as required.
	11. Participate in appropriate community, department, and agency meetings as assigned.
	12. Provide accurate, complete, and current written and database records/files.
	13. Other duties as assigned.

**SPNS Housing Case Manager (1.0 FTE)**

**Scope of Work:**

The Housing Case Manager works with the staff and management of Cascade AIDS Project (CAP) to provide high-quality, coordinated, strengths-based social services consistent with the agency’s mission. The individual works in Cascade AIDS Project’s Housing and Support Services Programs to provide services that include home-based housing case management, goal planning, information and referral services, advocacy with and on behalf of clients, and eviction prevention for individuals and families.

Responsibilities include: working with clients to develop housing plans, assisting clients in locating and securing affordable housing, mediation with landlords, completing forms, and entering data into the agency database in a timely and accurate manner. The Housing Case Manager works collaboratively and communicates effectively with clients, volunteers, CAP staff, and community partners. Other duties as assigned.

The person in this position is stationed in the CAP main office but will travel frequently throughout the six-county service area for meetings and client home-visits. Evening and weekend work is required. This is a non-management, union-represented position.

**Minimum Qualifications:**

* Bachelor’s Degree in human/social services field (social work, public or community health, psychology) or related field or two years’ experience relevant to the position
* Prior experience providing case management (or similar) services
* Demonstrated computer proficiency using Microsoft Office software (Word, Excel, Outlook) and working knowledge of the internet
* Excellent written and oral communication skills
* Successful experience working with ethnic, racial, economic and sexually diverse populations and persons who have experienced homelessness, persons with a mental illness and/or substance addiction
* Demonstrated ability to effectively collaborate with community stakeholders
* Good organizational and time management skills
* Ability to work independently with accountability
* Able to travel throughout the service area on a frequent basis
* Valid driver’s license and access to a reliable vehicle
* Available to work occasional evenings and weekends

**Preferred Qualifications:**

* Master degree in human/social services field (social work, public or community health, psychology) or related field
* Verbal and written fluency in English and Spanish
* Knowledge of housing laws and local housing resources
* Experience working with persons exiting County, State or Federal Corrections
* Previous experience working with people with HIV

**Essential Job Functions:**

* 1. Provide housing placement, supportive case management, and eviction prevention with and on behalf of clients who are homeless or at risk of becoming homeless using a supportive strengths-based model that promotes client self-determination and independence
	2. Work in collaboration with medical case managers, medical providers, or other providers involved in client care, to provide coordinated comprehensive care to PLWHA with a focus on housing stability
	3. Carry an active client panel of approximately 70 program eligible clients, assisting with eviction prevention, housing planning, advocacy, mediation, and information and referral
	4. Complete comprehensive housing assessments, goal planning, linkage to services, and advocacy for and with clients
	5. Makes appropriate referrals to mental health, substance abuse, HIV prevention, or other community partners as needed to support client self sufficiency
	6. Fax, mail or hand deliver a copy of each client’s housing plan to the medical case manager and provide regular updates as to the progress of each client towards achievement of their goals
	7. Establish professional relationships with landlords to create new housing resources and share the information with colleagues
	8. Maintain current information on housing opportunities, community resources and applicable laws and share the information with colleagues
	9. Compile and coordinate information on local alcohol and drug, mental health, food, clothing, and other resources for clients and share the information with colleagues
	10. Assist in the development of culturally appropriate programs and the recruitment of clients for those programs
	11. Design and produce written materials in support of the program either as an individual or as a member of the team
	12. Provide accurate, complete, and current written and database records/files
	13. Meet all contract requirements and provide supporting documentation, including program performance data and reports, as required
	14. Work collaboratively with and communicate effectively with CAP staff, volunteers, community partners, and clients
	15. Attend trainings and educational opportunities to remain current on housing, HIV, case management, and other relevant professional issues
	16. Other duties as assigned

*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>