TOTAL CARE SERVICES, INC.

Helping Others Meet Life's Challenges

JOB DESCRIPTION

POSITION: Coordinator of Community Services
REPORTS TO: Program Supervisor
WORK SCHEDULE: 8:30 am – 5:00 pm (flexible as needed)

STATUS: **__X__ Full-time** **_____ Part-time**
Consultant/Contract

__X__ Exempt **_____ Non-exempt**

SCOPE OF POSITION:

The Coordinator of Community Services (CCS) manages a case load of individuals with intellectual and developmental disabilities and supports those individuals so they are able to lead full lives by identifying, linking and coordinating a variety of supports and services, for the individuals within their community. The Community Coordinator supports each individual by developing an Individualized Care Plan, which shall reflect the individual's strengths, needs, personal goals, choices and values, assuring the individuals respect and dignity. All services provided the individuals served are to be based upon the principle of preferences, needs, desires and goals to assist the individuals become fully integrated into the community and achieve their optimal independence. The Coordinator of Community Services is responsible for entering case notes and billable services into Maryland's LTSS system to achieve 28 billable units per day.

PERFORMANCE STANDARDS: The Coordinator of Community Services shall enter 28 billable units or more into LTSS each day worked/140 units per week.

ESSENTIAL JOB FUNCTIONS AND RESPONSIBILITES:

- Completes Person Centered Plan (PCP) within the first 30 days of notification that Total Care Centers for Support Services is the provider of community coordination services;
- Complies with all State and Federal statutes, regulations, and policies; and demonstrates competency-based skills and working knowledge in the following areas: (a) Negotiation and conflict management; (b) Crisis management;
- Actively documents electronically in real time all contacts with individuals, family members, agencies, health care providers and other stakeholders;
- Develops the Annual PCP for individuals specifying preferences and supports and services;
- Facilitates team meetings with individuals to include lawyers, family members and/or other stake holders;
- Conducts regular monitoring for each individual served through Total Care Centers for Support Services' community coordination system;

- Conducts face-to-face monitoring, team meetings, telephone monitoring, and visits as needed to ensure the individual's health, safety and optimal satisfaction;
- Explores and accesses alternative supports and or funding sources to meet identified individual needs;
- Researches eligibility and ensure benefits are active and readily available;
- Monitors all reportable incidents as defined in Developmental Disabilities Administration (DDA) reportable incident policy;
- Educates individuals on identifying goals and choice of natural and community supports to enhance their lives;
- Properly notify team of meetings and other important events pertinent to the individual's care;
- Monitoring must occur at least once in each of the different service delivery settings (i.e. day program, vocational setting, home/residential setting, etc.);
- Prepares and submits "Request for Changes" and modifications to the IP and/or services in the IP in accordance with the Total Care Services Support Services policy;
- Applies or re-applies for all necessary programs, services or supports in a reasonable amount of time to prevent or remedy a gap in Medicaid or any other eligibility to the individual;
- Identifies new medical, social, health services, behavioral services, adaptive equipment needs, and other needs during all monitoring visits, phone calls, and other interactions with the individual and/or his/her family;
- Establishes and maintains working relationships, respond to individuals in a timely manner and use independent judgment and initiative to access services;
- Works collaboratively with different groups or services systems to identify coordinate and assure appropriate services;
- Facilitates empowerment of individuals through promoting independence, person centered planning, self-determination and creativity;
- Conducts detailed analytical evaluations and prepares detailed reports and practices;
- In the case of discharges, assists with transitioning and transfer activities in an expeditious manner to ensure continuity of support/services;
- Assists in planning for, monitoring, and evaluating all operations of the Community Coordination program;
- Works cooperatively with individuals, service professionals, and others to ensure that necessary supports and services are located and implemented;
- Able to be flexible, work from home, and or community;
- Able to be an independent worker who requires minimal supervision to fulfill the job duties listed below as well as other job duties as assigned;
- Performs all duties described, and others as required, using the mission of the organization.
- Ability to establish and maintain working relationships, respond to individuals in a timely manner and use independent judgment and initiative to access services;
- Ability to work collaboratively with different groups or services systems to identify coordinate and assure appropriate services;
- Ability to facilitate empowerment of individuals through promoting independence, self-determination and creativity;
- Ability to assist with transitioning and transfer activities in an expeditious manner to ensure continuity of support/services, in the case of a discharge;
- Ability to assist in planning for, monitoring, and evaluating all operations of the Community Coordination program;
- Must be a licensed driver and have own transportation with valid insurance.
- Must be able to apply professional level of knowledge of federal and state assistance programs for MH/DD populations.
- Knowledgeable in case management principles, procedures, and practices.
- Bachelor's degree or Master's degree in human service field.

- Completion of DDA Core training and other required trainings by DDA; demonstrates ongoing commitment to developing and enhancing professional skills through participation in agency staff meetings and outside training opportunities.
- Knowledge of Comprehensive Waiver services and developmental disabilities field.
- Must be a U.S. citizen or alien who is lawfully authorized to work in the U.S.
- Must be able to work a flex schedule and respond to crisis situations.
- Effective written and oral communication skills in addition to excellent time management skills.
- Proficient in using with Microsoft Office and Excel; ability to learn new technologies.

DECISION MAKING:

- On a regular and continuous basis, exercises administrative judgment and assumes responsibility for decisions, consequences and results
- Carries out responsibilities in a manner that brings credit to himself/herself and to Total Care services, Inc.
- Refrains from personal and professional activities which might reflect negatively on the integrity of Total Care Services, Inc. and/or have an impact on the organization and the quality of services that are delivered.
- Makes safe and sound decisions representing Total Care Services in a professional manner at all times
- Must be responsible, reliable, and able to carry out job functions

PHYSICAL REQUIREMENTS:

- Must be able to lift up to 20lbs, carry laptop, briefcase, files, folders, etc. - 20%
- Must be able to drive to and from meetings and monitoring in the community – 40%
    - Areas include Southern and Central Maryland.
- Must be able to sit to input data into the computer and LTSS– 30%
- Reaching, pulling, pushing and bending – 5%
- Walking up and down stairs – 5%

SIGNATURE

This document describes the essential functions and qualifications for the Coordinator of Community Services position. My signature indicates that I have read, understand and agree to perform the essential functions of the Coordinator of Community Services position and confirm that I meet the qualifications for accepting the position.

Employee Name (Print)	Date
Employee Name (Signature)	Date
Direct Supervisor	Date