TOTAL CARE SERVICES, INC.

Helping Others Meet Life's Challenges

Position: Supports Planner

Reports To: Supports Planner Supervisor

Work Schedule: 8:00am- 5:00pm **(flexible as needed)**

Status: **__X__ Full-time** **____ Part-time** **____ Consultant/ Contract**

__X__ Exempt **____ Non-exempt**

SCOPE OF POSITION:

The Supports Planner assists people with complex medical and/or behavioral health needs, older adults and/or adults, children, and youth with disabilities and their families in navigating, identifying, and accessing needed supports and services enabling the person to have a full and meaningful life. The Supports Planner supports each person by incorporating principles of self-direction and person-centered planning as well as available reports to develop a Plan of Service and provide ongoing case management. The role of the Supports Planner requires kindness, patience, skillful communication, computer expertise, resourcefulness, time management skills, the ability to network on behalf of participants, and knowledge of many provider and community resources within the service areas of program participants.

ESSENTIAL JOB FUNCTIONS AND RESPONSIBILITES:

- Educate applicants/participants on identifying goals and choice of natural and community supports to enhance their lives
- Facilitate empowerment of applicants/participants through promoting independence, person-centered planning, self-determination and creativity
- Identify, coordinate, and link the participant with appropriate supports and services which reflect the person's strengths, needs, personal goals, choices, and values
- Research eligibility and ensure benefits are active and readily available
- Provide ongoing support and monitoring to maintain the participant's continued Medicaid eligibility and waiver enrollment
- Explore and access alternative supports and or funding sources to meet the identified needs of the person
- Work collaboratively with applicants/participants, service professionals, and others to ensure that necessary supports and services are located and implemented
- Follow up with the Local Health Department (LHD) and Maryland Department of Health (MHD) for completion of the assessment and Plan of Care
- Coordinate a Plan of Service that reflects the person's desired level of self-direction and is based upon the principle of preferences, needs, desires and goals to assist the person to become fully integrated into the community and achieve their optimal independence
- Responsible for entering case notes and billable services into LTSS*Maryland*
- Actively documents electronically in real time all contacts with participants, family members, agencies, health care providers and other stakeholders
- Develop the annual POS for participants specifying preferences and supports and services
- Conduct face-to-face monitoring, team meetings, telephone monitoring, and visits as needed to ensure the participant's health, safety and optimal satisfaction
- Monitor all reportable events (RE) as defined in Maryland Department of Health (MDH) RE policy
- Prepare and submit Freedom of Choice (FOC) form and modifications to the POS and/or services in the POS in accordance with MDH policy

- Apply or re-apply 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 participant
- Identify new medical, social, health services, behavioral services, adaptive equipment needs, and other needs during all monitoring visits, phone calls, and other interactions with the participant and/or his/her family
- Establish and maintain working relationships, respond in a timely manner and use independent judgment and initiative to access services
- Conduct detailed analytical evaluations and prepares detailed reports and practices
- In the case of discharges, assist with coordinating and facilitating transition/transfer activities from institutions into the community in an expeditious manner to ensure continuity of support/services
- Follow principles of self-direction and person-centered planning model
- Follow the Department and TCS' conflict-free case management policy and procedures
- Follow all HIPAA guidelines for the protection of Personal Health Information (PHI/ePHI)
- Completion of the MDH's new supports planner training and other required trainings by MDH
- Demonstrate ongoing commitment to developing and enhancing professional skills through participation in agency staff meetings and outside training opportunities

KNOWLEDGE, SKILLS AND ABILITIES:

- 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 assigned;
- Perform all duties described, and others as required, in alignment with the mission of the organization.
- Knowledgeable in case management principles, procedures, and practices for people with complex medical and/or behavioral health needs, older adults and/or adults, children, and youth with disabilities
- Must be able to apply professional level of knowledge of federal and state assistance programs for people with complex medical and/or behavioral health needs, older adults and/or adults, children, and youth with disabilities
- Familiarity with Medicaid and Non-Medicaid community resources and services to support participants;
- Knowledge of Home and Community Based Waiver services

DECISION MAKING:

- Ability to multi-task, prioritize work, meet deadlines and produce quality results on time with attention to detail
- Ability to make ethical decisions which comply with TCS Code of Conduct, State and Federal regulations and adhere to all requirements and updates as they are made
- Refrain from personal and professional activities which may result in a Conflict of Interest and/or negatively impact the organization
- Ensure that any files and information shared digitally are shared in a manner that is secure and compliant with HIPAA guidelines
- Obtain proper disclosures and authorizations prior to sharing information internally or externally

QUALIFICATIONS:

- Must be a licensed driver with reliable transportation, valid insurance, and a good driving record.
- Bachelor's degree in human services field incl. psychology, social work, sociology, nursing, counseling, sociology, or related field or equivalent work experience pertaining to case management for people with complex medical and/or behavioral health needs, older adults and/or adults, children, and youth with disabilities:
- Must be a U.S. citizen or alien who is lawfully authorized to work in the U.S.
- Must be able to pass a criminal background check
- Must be flexible, able to work from home and/or community, and respond to crisis situations, including on nights and weekends
- Effective written and oral communication skills

- Excellent organization and time management skills.
- Proficient in using Microsoft Office; ability to learn new technologies.

WORKING CONDITIONS AND ENVIRONMENT:

- Must be able to lift up to 20lbs, carry laptop, briefcase, files, folders, etc.
- Must be able to drive to and from meetings and monitoring in the community
- Must be able to sit to input data into the computer
- Reaching, pulling, pushing and bending
- Walking up and down stairs
- Office equipment must be used only for TCS job functions
- Must maintain access to secure and reliable internet

SIGNATURE BLOCK:

This document describes the essential functions and qualifications for the position. Your signature indicates that you have read the position description and understand the essential functions and qualifications of the position.

_____	_____
Employee Name (Print)	Date
_____	_____
Employee Name (Signature)	Date
_____	_____
Direct Supervisor (Signature)	Date
_____	_____
Human Resources Director (Signature)	Date