Community Transition Liaison Coordinator

HESSCO is currently accepting resumes for a full-time, Community Transition Liaison Program Coordinator in the Home Care Department. The successful candidate will report to the Home Care Supervisor.

HESSCO is an Affirmative Action/Equal Opportunity Employer and encourages all qualified candidates from diverse backgrounds to apply.

The Community Transition Liaison (CTL) Coordinator will provide consumers who wish to transition from institutional setting into the community with options, resources, and assistance. The Community Transition Liaison Program Coordinator will actively collaborate with RNs and/or Care Managers, nursing facilities and other programs or community resources and consumers with unique needs who may require specialized supports and care plans in favor of fostering meaningful community living.

Qualifications and Essential Functions:

Acts as the onsite point of contact for residents, families, health care proxy (HCP) and nursing facility (NF) staff related to transitions from NF to community. Visits residents to increase awareness of service and introduce transition to the community as a potential option.

Will Actively collaborate with RN's and/or Care Managers

Participates in resident, family and/or HCP conversations to inform options and transition planning.

Completes the directional screening tool to determine potential appropriateness for referrals to HSBS Waivers and other programs to support the transition to the community and meet the consumer's needs once in the community setting.

Facilitates person-centered planning and needs assessment.

Begins the process of gathering necessary documentation and identification needed for housing applications and other public benefits.

Completes referrals to other programs and follows-up referral to ensure timely transition.

Participates in Interdisciplinary Discharge Planning (IDP) meetings and facilitates communication among the consumer, family members and community agencies.

Participates and facilitates in discharge planning meetings with the consumer, family, nursing facility staff and other agencies that will support the consumer in the community upon discharge.

Coordinate with state programs and other teams.

Provides supervision, direction, and oversight to the CTLP Case Assistant.

Minimum Requirements:

Bachelor's degree in social work, human services, nursing, psychology, sociology or a or a related field OR a bachelor's degree in another discipline and demonstrates experience and/or strong interest in the field of human services via previous employment, internship, volunteer activity and/or additional studies.

Must possess knowledge of long-term care, case management, discharge planning, community resources, programs, and benefits to help support an individual's transition from an institutional to a community setting.

Access to secure high-speed internet required.

Valid MA driver's license and daily access to reliable vehicle.