JOB DESCRIPTION AND PERFORMANCE EVALUATION

TITLE: TRANSITION COORDINATOR

EMPLOYEE: _____MANAGER: _____

I. SUMMARY OF JOB

Offer and coordinate all aspects of statewide transition services to Money Follows the Person individuals who meet the qualifications and are selected to transition to the ICWP, SOURCE or CCSP waivers.

II. MAJOR AREAS OF RESPONSIBILITY

Code of Conduct

1. Always works as a team player to meet nursing facility residents' wishes related to transitioning into the community.
2. Within scope of all applicable regulations and requirements, the Transition Coordinator will support other team members in accomplishing their job duties in order to "get the job done" timely and accurately.
3. Holds self and team members accountable for knowledge of and full compliance with customer service performance standards as listed on all team members job descriptions.
4. The customer is defined as anyone with whom staff comes into contact within the course of fulfilling contract requirements.
5. Participates in program planning and in the efficient, effective management of resources.
6. Supports and participates in quality improvement activities.

Job - Specific Areas of Responsibility

1. Distribute information handouts and/or brochures/flyers, as developed by the Department of Community Health.
2. Recruit and obtain potential candidates from a variety of referral sources to include, but not limited to, institutional staff, Long Term Care Ombudsman, Minimum Data Set, point of entry systems, individuals, and families.
3. Conduct preliminary screenings to determine potential for living in the community utilizing the tool developed by the Department of Community Health.
4. Obtain access to all records that exist within the nursing/institutional facility.
5. Obtain permission to release these records for screening, using the Authorization for Release of Information and Informed Consent Form as provided by the Department of Community Health.
6. Build a personal profile of the individual that includes medical, financial, functional, and psychosocial information, and identify the individual's need for housing, transportation, and other community-based services.
7. Coordinate with the institution's discharge planner/social worker and collaborate with the individual and natural support network in the completion of the application and referral

for waiver services.

8. Refer to appropriate waiver intake and evaluation team and act based upon their recommendation(s).
9. Identify and document members of the Transition Team, to include, but not limited to individual, family, natural support network, institutional staff, waiver staff, physician, peer support network, transition coordinator, legal aid, and home and community-based provider staff.
10. Conduct face-to-face interviews and develop written Person-Centered Individual Transition Plans with Transition Team Members utilizing agreed upon tool for plan development.
11. Present transition plan to the Transition Team Leader for approval.
12. Conduct or refer for the face-to-face baseline Quality of Life survey for each individual transitioning to the community to arrange for the Quality-of-Life evaluator to conduct the QQL survey with the Individual 11-12 months post community placement, and at 23-24 months post placement.
13. Collaborate with the Transition Team regarding the completion of the Waiver Assessment and Plan of Care (Service Plan) in tandem with the Transition Plan to facilitate a smooth transition.
14. Work in partnership with all members of the Transition Team to coordinate MFP services and waiver services, to include, but not limited to, housing, trial visits, transportation, household furnishings, household goods, and supplies as needed.
15. Contact DCH Member Services and change the Individual's eligibility from nursing facility/institutional to community based.
16. Assist the individual in completing the proper documentation to stop their Social Security (SSI/SSD) checks from going to the institution.
17. Assist the Transition Team, as outlined in the Transition Plan, on moving day, for activities such as assuring moving day expenses, and assisting in the testing of the emergency back-up system.
18. Issue vouchers for goods and services as approved by the Individual Transition Plan.
19. Refer to Long Term Care Ombudsman when deemed necessary.
20. Follow up with the individual during the first week and monthly thereafter for 12 months post transition.
21. Maintain records on all members interviewed and transitioned; submit reports in accordance with DCH and federal requirements.

III. QUALIFICATIONS

Education: Bachelor's Degree, Associate's Degree or Registered Nurse

Experience: A minimum of one year in a Human Services position required.

Preferred Skillsets:

- Demonstrated level of interpersonal skills necessary to communicate with individuals receiving services, referral sources, staff, and contract representatives.
- Demonstrated ability to analyze needs and to initiate and fulfill services to people.
- Comfortable with technology such as mobile platforms and data systems.
- Knowledgeable in Nursing Home operations.

- Experience with managing case loads and/or projects of a similar size and scope.
- Knowledge of Community Medicaid resources (Waivers).
- Understanding of Person-Centered philosophy.
- Understanding of Person Directed planning and/or case management.
- Advanced level of independent judgment.
- Ability to problem solve and troubleshoot various situations.

Other Requirements:

- Valid driver's license.
- Proof of automobile insurance.
- Reliable transportation.
- Satisfactory completion of background check as required by program regulations.

IV. PHYSICAL REQUIREMENTS

A. WORKING CONDITIONS
Works in climate-controlled office, facilities and/or remotely.
Potential for heavy workloads with deadlines.
At times can be stressful.

B. PHYSICAL DEMANDS
Prolonged sitting may be required.
Prolonged use of computer may be required with intense visual concentration.
Operates motor vehicle as required, with long range travel a probability.
May require lifting and handling of office products up to 50 pounds.
Mobility required but can rest at will.

V. TRAINING REQUIREMENTS

Transition Coordinators will attend all training required by the Division of Aging Services.
Transition Coordinators will attend all training required by the Department of Community Health.
Required training for Transition Coordinators within one (1) year of taking position:

- Adult Crime Tactics training (provided by the Forensic Special Investigation Unit, administered by DAS)
- HIPAA

Suggested Competencies:

- Medicaid Waivers
- Information & Referral
- Nursing Home Operations

I have read and understand the job description for Transition Coordinator and am able to perform the essential functions of the position.

_____ _____

Signature **Date**

_____ _____

Administrator or Designee **Date**

Employee comments:

_____

_____

_____

Name: _____ Date of Hire: _____ Evaluation Date: _____

Performance Appraisal

I certify that my supervisor has reviewed my performance appraisal results with me. My signature does not necessarily indicate that I agree with the appraisal results.

_____ _____
Employee's Signature Date

_____ _____
Supervisor's Signature Date

Performance Summary

(Note: A plan to correct the behavior must accompany appraisal for 2 or more below expected ratings, for ratings of 1 or 3 the evaluator must include a brief explanation to support the below of above expected level of performance ratings.)

Overall Average Rating: _____ Standard with the ratings of 3:

Please identify what Goal the Company needs to implement for this person:
Goal:

Please identify the Personal and Professional Goals of the Employee:
Personal Goal:

Professional Goal: