**Department of Health: Open Doors Program**

**Transition Specialist**

**Reports to: Director, Open Doors Program**

**Travel Required:** The Transition Specialist’s office is located in Medford, N.Y. but job responsibilities will require for the individual to travel through-out Nassau and Suffolk County. Conference in Albany to be attended as needed.

**Reliable car a must.
Salary Range:** $40,000-$42,000
*Health Insurance (NYSHIP) at no cost to employee, starting after 3 month probationary period*

*Vision and dental insurance available at a low cost*

*Extensive Holiday schedule and Paid Time Off*

*Mileage reimbursement for job related travel*

*Family friendly environment*

*403B offered*

**Position: Full time; 35 hours per week; (does not include lunch). Applicants will be trained.**

# Qualifications

* Minimum of aBachelor's degree in Human Services, Education or related field, and two years of relevant experience working in a government agency in community based long term care projects or three years of professional experience administering a relevant Medicaid program in a local department of social services or other comparable work experience in a private setting.
* Preferred candidates should have a working knowledge of issues faced by persons of all ages who are in need of long-term care services, particularly with those related to nursing home transition, and a deep commitment to person-centered planning and consumer choice.
* Candidates should have basic knowledge of Medicaid eligibility and coverage, as well as 1915(c) Medicaid waivers, and/or willing to learn.

**Responsibilities**Transition Specialists will meet with individuals and/or their family members to identify what services they will need and assist them in accessing those services. Types of assistance may include but are not limited to:

# Identify specific services to meet the participant’s individual needs. Provide information to community programs and resources.

# Provide Community Preparedness Education to ensure that the individual has the information and skills needed immediately upon their return to the community.

# Refer participants to programs to meet their service needs, such as Housing Subsidy Programs, NHTD and TBI Waivers, MLTC Plans, Health Homes, and SPOA/SPAs.

# The TS will tailor a transition plan to the participant’s specific needs and wants and helps make their move to the community successful. The TS’s role is to identify and remove barriers to returning and integrating into the community. The TS will also follow-up with participants who transition at 11 months post-transition to ensure that their needs continue to be met in the community.

# Complete Qualify of Life Surveys at time of transition and 11 months post transition for DOH purposes.

* Coordinate visits to institutions, provide potential participants with unbiased information regarding available home and community-based services, participate in discharge planning, and coordinate with other relevant social service agencies involved in the discharge and transition care of the consumer.
* Explain peer mentor program to potential participants, and if appropriate, provide referral to the peer advocate program.
* Ensure all significant client data and service provision details are current and accurate, and that they are documented in a timely manner into the databases.
* Perform other program-related duties as assigned by the Program Director and Chief Executive Officer.

Revised 6/12/24