ELEMENT CARE

TITLE: Social Worker **UPDATED:** 8/5/2020

JOB FUNCTION: Social Work **FLSA STATUS:** Exempt

GENERAL SUMMARY:
The Element Care Social Worker participates in the planning, implementation and evaluation of care plans that meet the objectives, standards and policies of the PACE model of care. The social worker demonstrates proficiency in providing traditional social work services in a professional and respectful manner with the goal of helping older adults live safely and comfortably in their homes and communities for as long as they can.

Essential Responsibilities:

- Participates on the Interdisciplinary Team's initial assessments, care planning and on-going re-assessments of participant care.
- Attends IDT meetings; actively participates in team meetings by sharing pertinent information, providing follow up to assigned tasks and helps to develop participant's plan of care.
- Completes all assigned assessments – which include (initial, semi-annual, annual, service request and/or significant event).
- Assesses the psychosocial needs of the participant and provides supportive counseling, working collaboratively with behavioral health providers.
- Facilitates hospital, rehabilitation and nursing home (NH) admissions and discharges as determined by the Interdisciplinary Team. Ensures that PASRR documentation is completed for NH admission.
- Assists in the conversion process of the participant from community to long-term care. Works collaboratively with Medicaid Specialist, skilled nursing facility, and participant's caregiver to complete conversion.
- Arranges and facilitates family meetings, as needed.
- Refers participants and families to appropriate community services and acts as liaison and/or advocate with community organizations for participants.
- Maintains professional, accurate and timely social service documentation in the participants' medical records.
- Conducts participant council meetings as assigned.
- Works collaboratively with Director of Social Work and Behavioral Health provider to ensure guardianship is up to date. Educates participant regarding health care proxy (HCP). Assists participant in completion of HCP form.
- Works collaboratively with fiscal department to maintain participant insurance benefits and completes required documentation of fiscal information in the medical record.
- Reviews plan of care with participants, guardian, and/or activated health care proxy as assigned.
- Complete authorizations for home care and other approved services timely and accurately.
- Completes home and/or skilled nursing facility visits to assess participant as indicated.
- Works collaboratively with Palliative care team; Assists with end of life planning as indicated.
- Provides timely communication to appropriate staff regarding the following: (disenrollment, conversion to long term care, transfer of sites, participant and/or caregiver demographic changes).
- Reports allegations of abuse to appropriate state agency; provides support and resources to participant as he/she will accept; completes required documentation
- Performs other duties as required.
- Frequent local travel.

Job Specification:

- Current Social Work licensure in the Commonwealth of Massachusetts at the Masters level (L.I.C.S.W. or L.C.S.W.) required
- Minimum of 1 experience in Social Work providing traditional Clinical or Case Management services with a geriatric population
- Current C. P. R. Certification or ability to become certified
- Treat all participants in a welcoming and professional manner.
- Strong verbal, written and listening skills
- Ability to multi-task in a fast pace environment