Social Worker MSW Job

Requisition Number: 2017-1373
Program: LIFE Programs
Department: Social Services
Location: Beaver, PA
Type: Full-Time
Typical Work Hours: 8:30 a.m. to 5:00 p.m.
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Overview:
Within an Interdisciplinary Care Team setting, incumbent promotes and maintains the mental and social health of enrolled participants through assessment, treatment, teaching and counseling. Provides basic casework and consultation for LIFE Program participants. Facilitates communication between participants, their family and the Care Team. Responsible for the implementation of social work care plan and coordination of social work with other services.

Responsibilities:
• Under limited supervision and in accordance with all applicable federal, state and local laws/regulations and policies, procedures and guidelines, for this position are:
  o Using all information sources available, assesses participant's bio/psycho/social health status and social work needs;
  ▪ Completes assessments at admission and for semi-annual care planning according to regulatory requirements and as condition change indicate.
  ▪ Determines participant and family needs related to social support, financial support, counseling and housing.
  ▪ Confers with participant and family to identify participant's goals and expectations.
  ▪ Coordinates with the interdisciplinary team to develop a comprehensive care plan for each participant.
  ▪ Documents changes in a participant's condition in the medical record according to policy and procedures.
  o In cooperation with the Care Team, plans and performs bio/psycho/social interventions designed to keep the participant in the community and enhance quality of life to the greatest extent possible;
  ▪ Takes part in each assigned participant's assessment and reassessment, including initial and periodic, and the participant's plan of care. Is knowledgeable about participant's overall need and views the participant in a holistic manner.
  ▪ Provides individual and group supportive counseling and education to participants and their families as needed or prescribed in the care plan.
  ▪ Coordinates the completion of participants' health care wishes and advance directives in cooperation with their primary care physician, the participant and their family.
  ▪ Provides discharge planning in the event of disenrollment.
  ▪ Provides referral to outside therapeutic services as needed.
  ▪ Participates in the on-call schedule as required.
• Acts as participant's advocate and liaison between participant and various governmental and private agencies in order to maximize the participant's support network and obtain needed services.
  • Facilitates communication between participant and various government programs such as Medicaid, SSI, Medicare and Social Security.
  • May participate in inter-agency meetings as needed.
  • Assists participant in obtaining housing and eligibility for low income housing options.
  • Evaluates need for and assists with the set-up of money management systems for participants who require assistance.
  • Keeps up-to-date on changing rules and regulations regarding Medicaid and Medicare eligibility and other entitlement programs and services.
• Acts as participants advocate and liaison between participant, family and Care Team.
  • Facilitates communication between participant, family and Care Team to maximize or maintain participant's support systems.
  • Facilitates or participates in family meetings as required.
  • Participates in participant council.
  • Conducts family support groups, education or training sessions and routine Family Caregiver meetings for education, support and dialogue.
  • Facilitates participant therapy groups as necessary.
• Provides leadership within the Care Team to ensure continuity and coordination of care and for staff development.
  • Works with Center Director to provide orientation and in-service programs for Care Team to enhance staff understanding of bio/psycho/social issues and meet regulatory requirements and support performance improvement.
  • Coordinates with mental health-related providers including drug and alcohol treatment to arrange appointments and share pertinent information.
• In cooperation with the Coordinator of Quality Management participates in the Quality Management Program to support continued performance improvement
  • Completes and ensures completion of documentation of clinical services reviewing medical record to continuity and completeness.
  • Participates in quality studies according to the quality plan.
  • Recommends studies for the annual quality plan.
  • Participates in committees that support performance improvement.
• TRAINING: On an annual basis employee will have completed training including: the need of the participant in the center's targeted population, body mechanics/transfer techniques, voluntary reporting requirements involving abuse, neglect and exploitation, positive approach methods to manage behavior, and two (2) sessions, (totaling a minimum of eight (8) hours), targeted at enhancing the quality of care given and the employees job performance.
• Performs other duties as assigned.

Qualifications:
• Master's Degree (MSW) in Social Work from an accredited school of social work.
• Minimum of one (1) years' experience working with a frail or elderly population; Thorough working knowledge of current community health practice for the frail elderly from direct service experience; Working knowledge of the interdisciplinary model of care management; Experience working with cognitively impaired seniors; Must be able to relate well with seniors and their families to deal with sensitive issues and facilitate problem solving; Must be flexible.
• Working knowledge of computers, Microsoft Word and Excel required.