Community Service Navigator Regional Definition
(Approved by Commission in FY 2021 Annual Implementation Plan)

Regional Definition - Coordination of community support services for older adults and family caregivers at the individual and community level designed to assist consumers to navigate service delivery systems and access a wide range of home and community-based supports and services, public benefits and other resources to empower them to live independently.

Allowable Services:

The Community Service Navigator(s) are responsible for brokering and arranging new or existing community services while working to enhance formal and informal support in the service area. This includes providing internal and external home and community-based services and developing needed resources in collaboration with community partners, other community-based organizations and trained volunteers. In addition, the Navigators will identify and communicate with appropriate community agencies to arrange for services and evaluates the effectiveness and benefits of the services provided. A basic assessment and subsequent reassessment every six months and the monitoring of a service plan tailored to the consumer's needs.

Minimum Standards

1. Coordinate services in a designated service area.
2. Preference is for the Community Service Navigator services to be physically located in the service area.
3. Performs intake and screening of clients to determine needs and make referrals to internal/external services
4. Conducts telephonic and/or in-home assessment/reassessment in collaboration with a Registered Nurse ever six months.
5. Develops a basic service plan and orders services in collaboration with client, direct care workers and/or in-home service provider.
6. Provides follow up assistance to gauge quality of services.
7. Provides or facilitates options counseling and benefits counseling is an allowable function. These access components will link at-risk participants to the following services:

    a. Long Term Care Services
    b. Directly provided Home and Community-Based Services
    c. Arranged Home and Community-Based Services
    d. Public and Private Benefits
    e. Medicare / Medicaid Assistance Program
    f. Linkage to Primary Care, if needed
    g. Evidence-based Wellness Programs

h. Caregiver Education, Training and Support
i. Other programs and services

8. Assessment may be substituted with recently performed in-home service, care management and other assessments of partners.
9. This service will coordinate care across the targeted service area for older adults and caregivers through partnerships and volunteers

10. Maintain relationships with Wayne County Department of Human Services (Medicaid and Adult Home Help) , PACE, MI CHOICE Waiver, Assisted Living and Independent Living Facilities, Hospice, Home Health Agencies, local healthcare systems and other programs. The Community Support Coordination entities will coordinate services through managed care organizations through DAAA.

11. Act as a broker and program developer of services in the targeted area to ensure that seniors and caregivers are linked to resources that address their unmet needs through a service-specific collaborative network of organizations:

    a. Consumers
    b. Government
    c. Area businesses and/or corporations
    d. Fraternal organizations and/or foundations,
    e. Faith-based Organizations,
    f. ADRC partners in the area,
    g. DAAA designated community focal points
    h. Hospitals and Wellness programs
    i. Medicare-Medicaid Assistance Program

12. In-service training at least twice each fiscal year.