PATH Case Manager

Program: Projects for Assistance in Transition from Homelessness (PATH)
Organization: Jacky's Recovery Support Services (JRSS)
Employment Status: Full-Time, bilingual preferred (Spanish)
FTE: 1.0
Location: Salt Lake County, Utah
Reports To: [PATH Program Supervisor/Program Director]

Position Summary

The PATH Case Manager is a community-based position responsible for providing intensive, person-centered case management to individuals experiencing homelessness or at risk of homelessness who are living with serious mental illness (SMI) or co-occurring mental health and substance use disorders (COD).

The Case Manager serves as a primary coordinating point between outreach, behavioral health treatment, housing, benefits, healthcare, recovery support, and other community services. This position works closely with the PATH Peer Support Specialist and JRSS's clinical and recovery teams to ensure that individuals identified through street and shelter outreach, hospitals, crisis services, courts, treatment programs, and community referrals move from initial engagement toward treatment, housing stability, income stability, community connection, and long-term recovery.

Consistent with JRSS's community-based model, services are provided where participants are most comfortable and accessible, including shelters, encampments, courts, hospitals, community settings, partner agencies, JRSS offices, and housing locations.

Essential Duties and Responsibilities

PATH Eligibility, Enrollment, and Assessment

- Identify and engage individuals who meet PATH eligibility criteria, including persons experiencing homelessness or at risk of homelessness who have SMI or COD.
- Work collaboratively with the PATH Peer Support Specialist to conduct regular street, shelter, court, hospital, crisis-center, and community outreach.
- Receive and respond promptly to referrals from shelters, hospitals, behavioral health providers, courts, coordinated entry partners, crisis programs, treatment providers, and other community organizations.
- Complete required eligibility screening, intake, enrollment, assessment, releases of information, and program documentation.
- Verify homelessness or risk of homelessness using allowable documentation and coordinate confirmation of SMI/COD through existing clinical records, screening, provider coordination, or JRSS clinical assessment as appropriate.
- Ensure that PATH resources remain appropriately targeted to the population authorized under the program.

Individualized Case Management and Service Planning

- Develop an individualized, participant-driven service plan within required program timelines.

- Ensure each service plan addresses identified needs such as mental health treatment, substance use treatment, housing, income and benefits, healthcare, transportation, rehabilitation, social supports, safety, and community integration.
- Formally review and document each participant's service plan **no less than once every month**, modifying goals and interventions based on progress, barriers, participant priorities, and changing circumstances.
- Maintain frequent contact with participants according to acuity and need, including field-based contacts when office-based services are not appropriate or accessible.
- Coordinate services across JRSS programs and external providers to reduce fragmentation and duplication.

Behavioral Health and Recovery Coordination

- Facilitate timely access to JRSS's in-house behavioral health services, including psychiatric evaluation, medication management, outpatient mental health treatment, substance use disorder treatment, co-occurring disorder treatment, case management, and peer recovery support.
- Coordinate higher levels of care when necessary, including detoxification, residential treatment, intensive outpatient treatment, medication-assisted treatment, crisis stabilization, inpatient psychiatric care, and other specialized services.
- Participate in interdisciplinary case consultation with JRSS clinicians, peer specialists, and community providers as appropriate.
- Support continuity of care following hospitalization, incarceration, crisis intervention, detoxification, residential treatment, or other transitions.

Benefits, Income, and Financial Stability

- Assist participants with obtaining and maintaining SSI, SSDI, SNAP, Medicaid, housing assistance, and other eligible federal, state, and local benefits.
- Utilize SOAR-informed practices and/or coordinate with SOAR-trained partners to support SSI/SSDI applications.
- Assist participants in gathering identification, medical documentation, financial records, and other materials required for benefit applications.
- Provide budgeting, financial-literacy, and money-management support.
- Coordinate representative-payee services for eligible participants when JRSS is appropriately designated to provide such services.

Housing Navigation and Stabilization

- Assist participants with coordinated entry, housing applications, supportive housing, subsidized housing, vouchers, landlord engagement, and other housing opportunities.
- Work with housing authorities, coordinated entry teams, landlords, housing advocates, and nonprofit housing providers.
- Assist participants in obtaining documentation necessary for housing placement.
- Administer or coordinate allowable PATH housing assistance, including eligible security deposits, housing-matching costs, minor allowable housing-related costs, and one-time rental assistance to prevent eviction, in accordance with program requirements and JRSS fiscal procedures.
- Provide housing-retention support after placement, including budgeting, behavioral health coordination, landlord communication, and connection to ongoing community services.

Referral and Community Coordination

- Provide active, person-centered referrals to primary healthcare, specialty medical care, behavioral health treatment, substance use treatment, employment and vocational services, education, legal assistance, veteran services, housing, and other community resources.
- Use a warm-handoff model rather than passive referral whenever possible.
- Contact providers to confirm availability, assist with appointment scheduling, arrange transportation, and coordinate accompaniment when appropriate.
- Follow up after referrals to determine whether services were successfully accessed and address barriers when they were not.
- Participate in coordinated case conferencing, discharge planning, and cross-agency service coordination.
- Maintain productive relationships with Continuum of Care partners, behavioral health providers, healthcare systems, courts, shelters, housing organizations, and other community partners.

Habilitation, Rehabilitation, and Community Stability

- Assist participants with activities and skills necessary for greater independence, including budgeting, daily living, transportation, social and interpersonal skills, medication self-management, and community integration.
- Connect participants with pre-vocational and vocational training, employment resources, education, rehabilitation services, and other skill-development opportunities.
- Coordinate JRSS psychoeducational groups, recovery activities, social connection opportunities, and other community-based supports.

Documentation, Data, and Quality Assurance

- Maintain timely, accurate, confidential, and complete participant records.
- Enter outreach, enrollment, service, referral, housing, and outcome information into all required PATH and JRSS data systems, including HMIS and PDX when required.
- Track participant progress toward required PATH performance measures.
- Participate in case reviews, quality-assurance activities, chart audits, program evaluation, and performance-improvement activities.
- Protect participant confidentiality and comply with applicable privacy, informed-consent, and information-sharing requirements.
- Complete all reports and documentation within established JRSS and contract timelines.

Required Training and Professional Development

The PATH Case Manager will complete and maintain required or assigned training in areas including:

- PATH eligibility and program requirements
- HMIS and PDX documentation
- Housing First
- Trauma-Informed Care
- Motivational Interviewing
- Person-Centered Planning
- SOAR
- Crisis intervention and de-escalation

- Suicide prevention
- Naloxone administration and overdose prevention/response
- Harm reduction
- SMI, SUD, and co-occurring disorders
- Cultural humility and culturally responsive services
- CPR/First Aid as required by JRSS

Qualifications

- Experience providing case management, behavioral health, homelessness, housing, social services, or closely related community-based services.
- Demonstrated ability to engage individuals experiencing homelessness, SMI, SUD, COD, justice involvement, or significant behavioral health instability.
- Knowledge of community behavioral health, housing, public benefits, healthcare, and social-service systems.
- Ability to work independently in community and outreach environments while functioning effectively as part of an interdisciplinary team.
- Strong documentation, organization, communication, advocacy, and problem-solving skills.
- Ability to establish professional boundaries while developing trusting, respectful relationships with participants.
- Commitment to person-centered, trauma-informed, culturally responsive, recovery-oriented, and Housing First practices.
- Bilingual English/Spanish strongly preferred.
- Certified Case Manager credential, or ability to obtain required certification within an established timeframe, preferred/required according to JRSS and contract requirements.
- Valid driver's license, reliable transportation, and ability to travel throughout Salt Lake County as required for outreach and participant services.

Core Competencies

Compassion and respect; participant choice and self-determination; cultural humility; relationship-building; crisis response; collaborative problem-solving; housing and benefits navigation; behavioral health coordination; accurate documentation; professional boundaries; teamwork; reliability; and commitment to recovery and community inclusion.