



Community Health Resource Navigator

Supervisor: Care Coordination Manager

Status: Full-Time, Non-Exempt

Location: Hybrid Position – Montrose, Delta Counties, some travel to San Miguel County

Job Summary

The Bilingual Community Resource Navigator (CHRN) provides person-centered information, assistance, insurance enrollment, care coordination, and community resource navigation services to community members, older adults, adults with disabilities, caregivers, and other community members.

This position helps individuals identify goals, understand available options, access services, and overcome barriers that impact health, independence, and quality of life. The CHRN works closely with clients, caregivers, healthcare providers, community organizations, and regional partners to improve access to services and support successful outcomes.

The successful candidate demonstrates strong bilingual communication skills (English/Spanish), systems thinking, and a commitment to quality service, collaboration, and continuous improvement.

Essential Duties & Responsibilities

Client Services & Resource Navigation

- Conduct person-centered assessments to identify client needs, goals, and barriers.
- Provide information and assistance, options counseling, care coordination, and resource navigation.
- Assist clients in accessing healthcare, behavioral health services, public benefits, long-term services and supports, housing, food, transportation, and other community resources.
- Support clients and caregivers in understanding options and making informed decisions.
- Assist community members in enrolling in health insurance and other public benefits.
- Follow up with clients to support progress and successful outcomes.
- Become or maintain Health Coverage Guide certification.
- Opportunities to become a certified Community Health Worker, or Medicare SHIP Counselor.

Community Partnerships & Outreach

- Build and maintain relationships with healthcare providers, community organizations, and regional partners.
- Participate in community meetings, outreach activities, and educational events.
- Educate community members and partners about available services and resources.
- Assist with maintaining resource and referral information.

Documentation & Quality Improvement

- Complete accurate and timely documentation in required systems.
- Track assessments, referrals, follow-up activities, and outcomes.
- Participate in quality assurance, quality improvement, and program evaluation activities.
- Identify service gaps and opportunities to improve client outcomes.
- Support implementation of new workflows, technology, and service delivery models.

Community Health Care Navigator

Other Duties

- Attend required meetings, training, and professional development activities.
- Perform other duties as assigned.

Required Education & Experience

- Two (2) years of experience working with diverse populations in healthcare, community-based organizations, or human services settings.
- One (1) year of experience in care coordination, case management, options counseling, community health work, client navigation, or related services.
- Bilingual English/Spanish proficiency required.
- Experience working independently in community-based or field settings.
- Proficiency with Microsoft Office and electronic documentation systems.
- Commitment to health equity, social determinants of health, and person-centered services.

Preferred Qualifications

- Bachelor's degree in social work, human services, public health, healthcare administration, or related field.
- Experience working with older adults, caregivers, and individuals with disabilities.
- Knowledge of Medicare, Medicaid, long-term services and supports, and public benefit programs.
- Training in Motivational Interviewing, Mental Health First Aid, trauma-informed care, or similar approaches.
- Knowledge of community resources in rural and frontier communities.

Personal Attributes

- Strong interpersonal and communication skills.
- Cultural humility and ability to work effectively with diverse populations.
- Organized, adaptable, and solution-oriented.
- Ability to maintain confidentiality and professional boundaries.
- Commitment to collaboration, learning, and continuous improvement.

Other Requirements

- Regular local and regional travel required.
- Valid driver's license, reliable transportation, and automobile insurance.
- Ability to work some evenings and weekends.

LOCATION:

- Hybrid position in Montrose and Delta County

SALARY AND BENEFITS:

- Starting salary range is \$22.00 - \$24.00 per hour, depending on experience.

Benefits Package:

- Up to 104 hours of vacation, 12 paid holidays, and up to 48 hours of sick leave annually.
- 100% employer-paid medical and dental insurance after 90 days.
- 3.5% 401k contribution match.

Community Health Care Navigator

- Flexible Spending Account after 90 days
- Employee Referral Program
- Mental Health Wellness Program
- Professional Development Opportunities.

Staff Signature: _____

Date: _____

CC Manager Signature: _____

Date: _____