Service Navigator

Funding for this project is provided by the Department of Developmental Services.

DDS is aware of and sensitive to the cultural and linguistic background of the individuals we serve and is committed to reducing disparities in purchase of service (POS) expenditures and promoting equitable access to services and supports.

This project is a collaboration with Alta California Regional Center and WarmLine Family Resource Center to provide navigation services to clients and their families from the following targeted populations:

- **17 - 40 years old, (0-3 years old starating July 1) *and***
- **Reside in Sacramento, Placer or Yolo Counties *and***
- **Spanish Speaking or African American (Russian speaking starting July 1)**

The goal of this project is to increase access and utilization of ACRC services by the target populations.

The Service Navigators will engage the clients and their families with the following objectives:

- Establish a relationship and gain trust to authentically engage clients and families to get the supports and services that they need based on their preferences and vision.
- To ensure that the client and family understand the services that are available and offered through ACRC and the impact of the services on their lives.
- Create an individualized Person Centered Plan to assist in identifying services and supports that meet the vision, dreams, desires and interests of the client. The Navigators will work closely with the client, family and regional center service coordinator to identify the services and supports to turn the vision into reality.
- Identify barriers to access and utilization of services and share this information with the regional center.
- Assist with navigating generic services, when and if appropriate.

Person Centered Planning

"Nothing about me without me"

An ongoing problem-solving process used to help people with disabilities plan for their future.

PURPOSE:

- ✓ *Look at an individual in a different way*
- ✓ *To assist the individual in gaining control over their own life.*
- ✓ *To increase opportunities for participation in the community.*
- ✓ *To recognize individual desires, interests, and dreams.*
- ✓ *Through team effort, develop a plan to turn dreams into reality.*

Service Navigation

HOW TO REFER A CLIENT?

1. Alta Service Coordinator (SC) will identify clients who match the criteria for the Service Navigator Program:

- ✓ 18- 40 years old (0-3 years old starting 7/20)
  and
- ✓ Reside in Sacramento, Placer or Yolo Counties
  and
- ✓ Spanish Speaking or African American (Russian speaking starting 7/20)

2. The SC will fill out a referral form and email to Kelly@warmlinefrc.org
3. Within 7 days, an email will be sent to the SC with the name and contact email of the Service Navigator. The Service Navigator may call the SC to get more information about the client's and family's barriers or needs.
4. The Service Navigator will contact the family within 10 days to schedule a time to review the program.

SERVICE NAVIGATION

The Navigators will work with clients and their families to prioritize needs and educate them on the regional center systems. ***The goal of this project is to increase access and utilization of ACRC services and to identify barriers to culturally appropriate services.***

Collaboration with the regional center is the key to success!

At the first meeting the Navigator will review the program and have the client and family complete a pre-survey. More importantly, the Navigator will take the time to listen to the client's and family's concerns and dreams and to build a trusting relationship.

If client and family approves, navigation services will begin, including

1. Educate clients and families about regional center and generic services.
2. Generic service assistance - the case management team will determine if assistance can be provided and the scope of assistance.
3. Assist families in transitioning their adult child from special education services to regional center adult services.

a. A Person Centered Plan (PCP) will be developed with input from key people.

4. In collaborations with the SC, assist the client in identifying appropriate services and programs that align with the PCP.
5. A post-survey will be given to the client and family to measure the increase in knowledge about services.