Chapter 5 : OhioKAN Service Delivery

During the Check-In

During the check-in, greet the caregiver or parent by name and identify yourself as a Navigator from the OhioKAN program. State the purpose of the check-in:

- To follow up on the Support Plan and check-in on identified action steps and referrals.
- To hear how their experience has been accessing or engaging with the services identified in the Support Plan.
- To see if any other needs have come up.

Priorities for the Check-In

Review the caregiver or parent's priorities for the check-in and ask which needs and referrals the caregiver or parent would like to discuss first. Due to time constraints, it may not be feasible to discuss each need and referral on the Support Plan during each check-in. It is acceptable to focus on addressing a single need during a check-in, for example spending an entire check-in completing a benefits application with a parent or caregiver. A full review of all needs should be completed once the service episode has been open for 90 days or more, see section titled Quarterly Support Plan Review.

Priority Needs and Referrals

Starting with the needs and referrals the caregiver or parent prioritized, ask about each referral made and summarize the caregiver's or parent's response in the Support Plan's Notes section. The response notes should be brief.

When discussing each referral, keep the following in mind:

- Has the person attempted to access the referral resource or take the action step?
    - If not, were there any barriers that prevented them from doing this?
    - If the person did not have time to act on the referral, help them think through a plan to do so by asking questions like, "Is there a time within the next week when you will have time to reach out to this organization?"
        - If the person has a plan to access a referral they have not yet attempted to connect with, ask them if they would like you to follow up again. Specify a best date or time of day to reach them and set yourself a reminder.
- If the caregiver or parent did attempt to access the referral resource, what was the result?
    - If the organization does not provide the service or has a waitlist, ensure this is documented and provide an alternative referral if possible. If an alternative referral is not possible because no other services are available, document this and elevate the

service gap to the Regional Coordinator.

- If the caregiver or parent was told they were not eligible for a service, clarify eligibility.

Since the last conversation, ask if any new needs have arisen.

- If new needs have arisen, document these in the Support Plan and provide additional referrals to address these needs.

Ask if the person feels all their needs have been met at this time and if no longer require Collaborate advocacy and navigation services.

- If yes, close the service episode.
- If no, explore additional needs and potential referrals with them. Document any new needs and referrals in the Support Plan.