[First Last Name]

[City, State] | [email@example.com] | [(000) 000-0000] | [LinkedIn URL]

PROFESSIONAL SUMMARY

[Detail-oriented] **Case Manager** with [X+] years of experience coordinating services for diverse populations in [healthcare / social services / community-based] settings. Proven ability to manage caseloads of [XX–XX] clients, conduct comprehensive assessments, and develop individualized care plans that improve client outcomes and resource utilization. Skilled in **interdisciplinary collaboration**, crisis intervention, and navigating complex benefits and community resources. Adept at maintaining accurate documentation, ensuring compliance with [HIPAA / state regulations], and building strong, trust-based relationships with clients and families.

PROFESSIONAL EXPERIENCE

[Senior Case Manager] | [Community Health Organization]

[City, State] | [MM YYYY] – Present

- Manage a complex caseload of [XX–XX] clients with [chronic medical, behavioral health, and social needs], completing biopsychosocial assessments and developing individualized service plans aligned with evidence-based practices.
- Coordinate multidisciplinary care with [nurses, physicians, social workers, behavioral health providers, and community partners], resulting in a [X% reduction] in missed appointments and improved continuity of care.
- Maintain timely and accurate documentation in [Electronic Health Record (EHR) / case management system: e.g., [Epic] / [CareLogic] / [Salesforce]], consistently meeting [100%] of internal audit and compliance standards for notes, authorizations, and reporting.

[Case Manager] | [Nonprofit Social Services Agency]

[City, State] | [MM YYYY] – [MM YYYY]

- Provided intensive case management to a caseload of [XX] adults and families experiencing [homelessness / housing instability / behavioral health challenges], including intake, eligibility screening, and ongoing service coordination.
- Linked clients to critical resources such as [housing programs, Medicaid/Medicare, SNAP, transportation, and vocational services], contributing to a [X% increase] in clients successfully accessing and retaining benefits within [12 months].
- Utilized [Motivational Interviewing, trauma-informed care, and strengths-based approaches] to support client engagement and goal attainment, achieving [X%] of clients meeting at least [two] major care plan goals within established timeframes.

EDUCATION

[Bachelor of Social Work (BSW)] | [Name of University]

[City, State] | [MM YYYY]

- Relevant coursework: [Case Management Practice, Human Behavior in the Social Environment, Psychopathology, Community Resources, Ethics in Social Work].

[Associate of Applied Science in Human Services] | [Community College Name]

[City, State] | [MM YYYY]

- Capstone project focused on [developing a community resource guide and referral workflow for at-risk populations].

SKILLS

- **Case Management & Client Services:** [Comprehensive assessments], [individualized care planning], [service coordination], [discharge planning], [follow-up and monitoring].
- **Clinical & Support Approaches:** [Motivational Interviewing], [trauma-informed care], [crisis intervention], [harm reduction], [strengths-based practice].
- **Systems & Documentation:** [Electronic Health Records (EHR)], [case management software: e.g., [Epic], [CareLogic], [Salesforce]], [Microsoft Office (Word, Excel, Outlook)], [secure documentation in compliance with HIPAA].
- **Resource Navigation:** [Public benefits (Medicaid, Medicare, SNAP, SSI/SSDI)], [housing programs], [community-based organizations], [referral and authorization processes].

- **Regulatory & Compliance:** [HIPAA], [confidentiality standards], [agency policies and procedures], [quality and utilization review support].
- **Communication & Collaboration:** [Client advocacy], [interdisciplinary teamwork], [conflict resolution], [culturally responsive communication] with diverse populations.
- **Organization & Time Management:** [Caseload prioritization], [task and deadline management], [accurate record-keeping], [data tracking and basic reporting].

PROJECTS & ADDITIONAL EXPERIENCE

[Care Coordination Workflow Improvement Project] | [Community Health Organization]

[MM YYYY] – [MM YYYY]

- Collaborated with a team of [case managers, nurses, and program coordinators] to map existing care coordination workflows and identify gaps in follow-up and documentation.
- Helped implement standardized [intake, assessment, and follow-up] templates in the [EHR/case management system], reducing average documentation time per client by approximately [X%].

[Community Resource & Referral Guide Initiative] | [Nonprofit Social Services Agency]

[MM YYYY] – [MM YYYY]

- Developed and maintained a centralized directory of [local housing, mental health, substance use, and employment resources] to streamline client referrals for the case management team.
- Conducted outreach to [community partners and service providers] to verify eligibility criteria, referral processes, and contact information, improving referral success rates for clients.