MARIAM CLINIC · VOLUNTEER ROLE DESCRIPTION

Patient Navigator

The single, consistent point of contact for an assigned panel of patients.

ROLE SUMMARY

Patient Navigators are the primary human connection between Mariam Clinic and its patients. Each Navigator is assigned a dedicated patient panel and carries those patients through the entire arc of their care — from first contact and eligibility screening, through enrollment and scheduling, into ongoing care coordination and long-term follow-up. This is a relationship-based role, not a task-based one: the emphasis is continuity over volume, and a Navigator who deeply supports a small panel is just as valuable as one who manages many.

AT A GLANCE

Reports To	Patient Navigator Team Lead
Time Commitment	3–10 hours per week, ongoing. Consistency is valued over volume.
Minimum Commitment	12 months
Typical Panel Size	5–15 patients, assigned based on your capacity and clinic need
Where You'll Work	Primarily remote (follow-up by phone and text), with in-person time at the clinic and community partner sites for outreach and enrollment
Ideal Candidate	Pre-health students (pre-med, pre-PA, pre-nursing), public health or social work students, or community members with lived experience navigating social services. Bilingual volunteers strongly encouraged.
Training Provided	Eligibility & enrollment procedures, motivational interviewing basics, HIPAA compliance, cultural sensitivity, and Navigator Handbook orientation

CORE RESPONSIBILITIES

Outreach & First Contact

- Introduce the clinic, answer questions, and begin building trust before any formal enrollment begins.
- Meet prospective patients at the clinic or at partner sites.

Eligibility & Enrollment

- Screen eligibility at intake using the clinic checklist, collect supporting documents, and complete enrollment into Mariam Clinic; re-screen annually to confirm continued eligibility.
- Screen for life events that may make patients newly eligible for Medicaid or Medicare (e.g., income changes, pregnancy, disability, dependent children, turning 65). Formally connect patients to relevant resources.
- Help patients enroll in coverage and assistance programs such as NC MedAssist, UNC Charity Care, and pharmaceutical patient assistance programs (PAPs).

Scheduling & Follow-Up

- Schedule intake and first clinic visits, send reminders, and confirm attendance before every appointment.
- Check in regularly by phone, text, or in person; follow up on missed appointments within 24–48 hours to understand barriers and reschedule promptly.

Care Coordination

- Serve as the liaison between patients and the clinical team: make sure patients attend appointments, understand their care plans, and follow through on referrals and prescriptions.
- After each appointment, confirm the care plan is being carried out as the provider intended and address remaining needs or barriers.

Social Resource Connection

- Identify social barriers to health — food insecurity, housing instability, transportation, legal and immigration concerns — and connect patients to community partners using the clinic's Wake County resource directory, coordinating with the clinic's Social Worker on complex needs.

Patient Advocacy

- Help patients understand provider instructions and follow up on open questions, so they feel informed, respected, and supported at every step of their care.

Documentation & Compliance

- Keep accurate, current records of panel status, follow-up activity, appointment history, enrollments, and referrals in the clinic's tracking system.
- Follow all Mariam Clinic policies and maintain full compliance with HIPAA and applicable patient privacy and confidentiality requirements.

WHAT YOU'LL GAIN

- **Longitudinal patient relationships** — follow real patients over time and see continuity of care, not just a single encounter, with direct, measurable impact: fewer missed appointments and patients connected to medications and specialist care they would otherwise go without.
- **Clinical exposure and mentorship** — work alongside the clinic's volunteer physicians and clinical team in an active free clinic; dedicated Navigators may shadow providers and receive mentorship aligned to their career goals.
- **A front-row view of the social determinants of health** — how eligibility, housing, food, and transportation shape whether people actually get care.
- **Skills you keep** — motivational interviewing, eligibility & enrollment, HIPAA compliance, health literacy, cultural humility, and SDOH screening, all valued across the health professions.
- **Credentials for your applications** — verified service hours, academic credit where your program allows, and eligibility to request a letter of recommendation after demonstrating consistent commitment and strong performance.

PREREQUISITES & ONBOARDING

Sign the HIPAA Privacy & Confidentiality Statement and the clinic's Confidentiality Agreement, and submit a photo ID, immunization record, COVID-19 vaccination card, and Hepatitis B vaccination series (or a signed waiver). HIPAA training and Navigator Handbook orientation are provided before you start.

HOW TO APPLY

Becoming a Patient Navigator takes three steps:

1. **Written application** — submit a short application at **mariamclinic.org/volunteer** or email **director.mariamclinic@gmail.com**.
2. **Phone interview** — we'll reach out to schedule a brief conversation about your interests and fit.
3. **Orientation & training** — attend clinic orientation (mission, HIPA