	The Johns Hopkins Health System PFS Policies and Procedures Manual	<i>Policy Number</i>	SYS007
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POLICY

This policy applies to the Johns Hopkins Health System (JHHS) Patient Financial Services (PFS) Department.

PURPOSE

To explain the process for requesting an assessment of a PFS Representative.

PROCEDURES

The assessment of PFS Representatives includes “new employees” (within six months of hire date) and staff who are candidates for promotion to a higher level. It is mandatory that all PFS Reps be assessed. This process is designed to help employees perform more efficiently and more effectively.

Complete the attached **Assessment Request Form** and forward it to the Training Manager.

- Any employee who does not score 70% or higher must be re-assessed within eight (8) weeks. The employee may continue to receive training and continue to sit for the appropriate assessment until he/she scores 70%. There is no such thing as “failing”; the results are used to determine training needs and are not part of the promotion process.
- Any employee who scores between 70% and 80% must attend additional training but will **not** need to be reassessed.
- All PFS Reps must be re-assessed annually, but the Assessment Request Form does **not** need to be completed for these annual re-assessments.

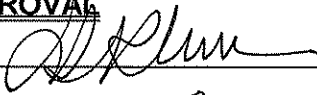
SPONSOR

Senior Director, Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years


APPROVAL



 Senior Director, JHHS

1/19/09

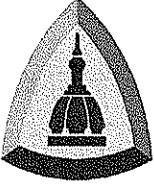
 Date



 Director, PFS Systems JHHS

1/5/2009

 Date

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JHHS — PFS Department

Assessment Request Form

For any employee who is ready to take an assessment, please complete this form and forward it to the Training Manager. In the event that an employee needs to repeat an assessment, he/she has eight (8) weeks to do so, and this form should be resubmitted to the Training Department. This form should be used both for "new-employee" assessments and "promotion" assessments.

Assessment Level to be taken: PFS I, II, III, IV: _____

Assessment Area: PFS Rep or Customer Service Rep: _____

Employee's Name: _____

Employee's Phone Number: _____

Employee's Immediate Supervisor: _____

Employee's Primary Area (e.g., Blue Cross, MC, HMO, etc.): _____

Manager's Name (please print): _____

Manager's Signature: _____

Date: _____