

## Patient Advisory Council Application Form

*Patient Advisory Council Members (PAC) are a group of patients, caregivers, and family members that partner with the Network to serve patients, improve facility outcomes, and seek ways to improve patient/staff relationships. The PAC assists the Network to identify ways to spread best practices as well as design/implement Quality Improvement Activities (QIAs) to promote patient-empowerment and engagement.*

### Complete the following information:

About You	
I am (check one):	<input type="checkbox"/> Patient <input type="checkbox"/> Family/Caregiver
If not a patient, is the patient in your life:	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatric ( <input type="checkbox"/> Age of Pediatric Patient)
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Secondary Phone/ Cell Phone	
Email Address	
About Your ESRD Experience	
Dialysis Facility Name	
Dialysis Facility Phone Number	
Number of years as a dialysis patient	
Number of years as a transplant recipient (as applicable)	
Current Treatment Type: (check one)	<input type="checkbox"/> In-Center Hemodialysis: M/W/F or T/T/S <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant
Previous Treatment Types: (check all that apply)	<input type="checkbox"/> In-Center Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant
Are you on a transplant waitlist? (circle one)	<div>Yes</div> <div>No</div>

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Connecting With You	
How often do you check your email (check one):	<input type="checkbox"/> daily <input type="checkbox"/> 2-3 times/week <input type="checkbox"/> only when expecting important messages <input type="checkbox"/> don't have email
Are you able to attend 3 or more meetings by phone per year?	<div>Yes</div> <div>No</div>
Your ESRD Expertise	
Why would you like to join the Patient Advisory Council (PAC)?	
Your Interests: Which project(s) would you enjoy working on? (check all that apply)	
<b>Patient and Family Engagement:</b> Assist the Network in developing education and initiatives to increase patient and family involvement in their own care	
<b>Hospitalization:</b> Reduce hospitalizations for patients	
<b>Kidney Transplant:</b> Help increase number of dialysis patients receiving a transplant	
<b>Vaccinations:</b> Share your ideas on ways to encourage patients to accept recommended vaccinations	
<b>Home Dialysis:</b> Help the Network understand how to educate patients on home therapy programs	

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Please read and check the appropriate statements below:

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\_\_\_\_ I authorize AHS/Network 8 and/or 14 to utilize my name and email address for specific Patient Advisory Council communications.

\_\_\_\_ I further authorize AHS/Network 8 and/or 14 to use my name where necessary in meeting minutes, and in listing PAC member names in reports to The Centers for Medicare and Medicaid Services (CMS).

Signature of Candidate: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Candidate (print): \_\_\_\_\_

**Submit completed form to the appropriate Network. Allow 5-10 business days for processing and follow-up.**

ESRD Network 8 (Alabama, Mississippi, Tennessee)  
Fax 601-932-4446

ESRD Network 14 (Texas)  
Fax # 972-503-3219

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