# 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): | ___Patient____Family/Caregiver |
| If not a patient, is the patient in your life: | ___Adult____Pediatric (___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) | ____In-Center Hemodialysis: M/W/F or T/T/S<br>____Peritoneal Dialysis_____Home Hemodialysis<br>____Transplant |
| **Previous Treatment Types:** (check all that apply) | ____In-Center Hemodialysis<br>____Peritoneal Dialysis_____Home Hemodialysis<br>____Transplant |
| **Are you on a transplant waitlist?** (circle one) | Yes No |

| Connecting With You | |
|---|---|
| **How often do you check your email (check one):** | ____daily<br>____2-3 times/week<br>____only when expecting important messages<br>____don't have email |
| **Are you able to attend 3 or more meetings by phone per year?** | Yes No |
| **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) | |
| **Patient and Family Engagement**: Assist the Network in developing education and initiatives to increase patient and family involvement in their own care | |
| **Hospitalization**: Reduce hospitalizations for patients | |
| **Kidney Transplant:** Help increase number of dialysis patients receiving a transplant | |
| **Vaccinations**: Share your ideas on ways to encourage patients to accept recommended vaccinations | |
| **Home Dialysis**: Help the Network understand how to educate patients on home therapy programs | |

# Patient Advisory Council Application

**Please read and check the appropriate statements below:**

____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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