920 Main Street, Suite 801
Kansas City, MO 64105

Main Telephone Number: 816/880-9990
Patient Only Toll-Free Telephone Number: 800/444-9965
Fax: 816/880-9088

Qsource- ESRD Network 12
Patient Advisory Council (PAC) Application

Overview

The Patient Advisory Council (PAC) provides the Network with the patient voice to help meet the needs of dialysis patients and their families and improve the quality of care they receive. The PAC is a diverse group of people that are on dialysis, have received a kidney transplant, or are the care partner/family member of someone with kidney disease. Members represent the states of Iowa, Kansas, Missouri, and Nebraska.

Membership Expectations:

- A commitment to a year term of office with the option of serving additional terms;
- Attend and participate in monthly scheduled meetings which may include webinars, conference calls, and one in-person meeting (travel costs are paid for by the Network). Lack of participation may result in dismissal from PAC;
- Strongly encouraged, but not required, to have access to a computer/tablet/smart phone for:
  - Contact by email
  - Participation in webinars
  - Participation in online surveys

Responsibilities:

- Provide input into the development of informational and educational materials for patients and families/care partners.
- Offer a patient perspective on the selection and development of all Network quality improvement activities (QIAs) for which patient engagement is required.
- Offer a patient perspective to the Network in interpreting the results of all Network QIAs and the development of interventions.
- Identify and present the needs and concerns of people living with kidney disease.
- Act as a liaison between the renal population and the Network.
- Provide information and feedback to the appropriate Network staff.
- Select one project committee to participate in for the year. Meetings will be held over the phone or webinar online.
- PAC members also have the opportunity to represent the Network at a national level through the ESRD Network Coordinating Council Learning and Action Networks

To apply: please complete the next four pages with the assistance of a facility staff representative.

PART 1: Patient Subject Matter Expert Application Form

Please complete the following information for consideration to participate on the Network Patient Advisory Council (PAC) and/or as a Network Patient Subject Matter Expert.

About You	
I am (check one):	____Patient____Family/Caregiver___Stakeholder
Name (First, Last)	
Address	
City, State, Zip	
Primary Phone	
Email Address	
I identify as:	☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other
Ethnicity: I identify myself as	____Hispanic/Latino_____Not Hispanic or Latino
I mainly speak:	____English ___Spanish Other: ___________
About Your ESRD Experience	
Dialysis Facility Name	
Dialysis Facility Phone Number	
Name of Referring Staff Member (must be included if staff member is referring candidate)	
Number of Years as a Dialysis Patient	
Current Treatment Type: (check one)	____In-Center Hemodialysis: M/W/F or T/Th/S ____Peritoneal Dialysis ____ Home Hemodialysis ____Transplant, if yes, number of years as a transplant recipient____
Previous Treatment Types: (check all that apply)	____In-Center Hemodialysis ____Peritoneal Dialysis ____Home Hemodialysis ____Transplant
Are you on a transplant waitlist? (circle one)	Yes No
Connecting With You	
Preferred Method of Contact	____ Phone ____ Email ____ Mail
How often do you check your email (check one):	_____daily _____2-3 times/week _____only when expecting important messages _____don’t have email
Are you able to travel out of state for face-to-face meetings? (circle one)	Yes No
Are you able to attend 2 or more meetings by phone per year? (circle one)	Yes No

PART 2: Background and Interest (please print clearly).

Do you have previous experience with Qsource- ESRD Network 12, other kidney related organizations, or experience helping at your dialysis clinic/transplant center? If yes, explain:

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____

____

Share any other leadership positions you have taken in other areas of your life.

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What motivates you to stay positive and to try to have a good quality of life no matter what? How do you set a good example for other dialysis patients/family members who might be struggling?

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Why are you interested in becoming a PAC member? What experiences or strengths do you have that would contribute to the efforts of the PAC to help improve the dialysis patient experience?

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____

If you are not currently a Network Patient Representative at a dialysis clinic are you willing to work with your current or a former dialysis center in this role? This is preferred but not required. ☐ Yes ☐ No

Thank you for completing your portion of the PAC application. Please remember to complete the signature page in Part 4. Now ask a staff member at the dialysis facility/transplant center if they would provide a recommendation for you to serve on the PAC by completing Part 3 and include their signature on the Application Form before submitting it by fax.

PART 3: Staff Recommendation (please print clearly)

Qsource-ESRD Network 12 would like for dialysis/transplant facility staff to help us get to know the patient/family member applying to serve on the Patient Advisory Council (PAC). Please complete the information below if you believe the applicant would be a good candidate for this role.

PAC Applicant Name					
Dialysis Facility or Transplant Center Information					
Facility name		CMS Certification Number (6 digit #)			
Address					
City		State		Zip	
Phone		Fax			
Recommending Staff Member Contact Information					
Name		Title			
Phone		Email			

Why do you think your nominee would make a good candidate for serving on the PAC?

____

____

____

How are they engaged in their (or their family member's) care and what type of example do they set for fellow patients/families/etc.?

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____

With this submission, I would like to recommend ________________________________ (patient/family member name) for consideration on the Qsource- ESRD Network 12's PAC.

- ☐ I affirm, as the facility representative, that the facility will support and work with this individual in their role as the Network PAC.

Please sign the staff signature on page 4 and return the completed application to the Network via fax at (816) 880-9088.

PART 4: Signature Page

Please complete the following information for consideration to participate in the Network PAC and/or as a Network Patient Subject Matter Expert.

Please read the following statements *(all must be checked to be considered):*

- ☐ I have read the PAC member responsibilities and participation/membership policy and agree to fulfill them to the best of my ability.
- ☐ I authorize the Network 12 and my dialysis center *(if applicable)* to utilize my name and email address for specific PAC and SME communications.
- ☐ I further authorize my Network to use my name where necessary in PAC and SME meeting minutes and in listing PAC and SME members in reports to the Centers for Medicare and Medicaid Services (CMS) and other business documentation.

Applicant Signature ________________________________ **Date:** __________

Staff Signature (if Applicable): ________________________ **Date:** __________

Thank you for your interest and recommendation.

Please submit completed forms to Qsource - ESRD Network 12. You may fax it to 816-880-9088 or mail it to 920 Main, Suite 801, Kansas City, Missouri 64105. If you have any questions, please contact us at 800-444-9965.

(Note: If we receive more applications than there are available slots, we may refer to your application at a later date, if additional SME participants are needed.**)**

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