Network 10 Patient Advisory Council Subject Matter Expert Application

The Patient Advisory Council (PAC) provides the Network with the patient voice to improve the quality of care and help meet the needs of dialysis patients and their families. 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.

About You

I am: ☐ Patient ☐ Family Member/Care Partner ☐ ESRD Professional

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code_____

Phone Number: _____ Email Address: _____

I Identify As:

☐ American Indian or Alaska Native

☐ Asian

☐ Black/African American

☐ Native Hawaiian or Other Pacific Islander

☐ White

☐ Other _____

Ethnicity:

☐ Hispanic/Latino ☐ Not Hispanic/Latino

My Preferred Language:

☐ English ☐ Spanish

☐ Other _____

About Your ESRD Experience

Leave blank if it does not apply to you.

Dialysis Facility Name: _____

Dialysis Facility Phone Number: _____

Name of Referring Staff Member (if applicable):_____

Years as an ESRD Patient/Family/Care Partner: _____

Current Treatment Type:

☐ In-Center Hemodialysis

- ☐ M/W/F
- ☐ T/Th/Sat

☐ Peritoneal Dialysis

☐ Home Hemodialysis

☐ Transplant

Years With Transplant: _____

Previous Treatment Types:
(check all that apply)

☐ In-Center Hemodialysis

☐ Peritoneal Dialysis

☐ Home Hemodialysis

☐ Transplant

Are you on the transplant waitlist?

☐ Yes ☐ No

Connecting With You

Preferred Method of Contact:

☐ Phone ☐ Email ☐ Mail

How often do you check your email?

☐ Daily
☐ 2-3 times per week
☐ Only when expecting important messages
☐ Don't have email

PAC Meetings:

There are at least eight PAC meetings each year. Our hope is that you can attend at least four. Please communicate when you cannot make a meeting so that we can be sure to collect your feedback before the meeting on PAC-specific issues to share with the other members.

Please read about PAC member responsibilities at:
https://esrd.qsource.org/patients/patient-advisory-council/

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 Qsource ESRD Network 10 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 & Medicaid Services (CMS) and other business documentation.

Applicant Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Please contact Network 10 with any questions or submit this completed form in one of the following ways:

Email: PatientAdvisoryCouncil@qsource.org

Fax: 317-257-8291

Mail: Qsource ESRD Network 10
c/o Patient Services,
911 East 86th St., Suite 30
Indianapolis, IN 46240

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