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/Caregiver

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

I Mainly Speak:

- ☐ English
- ☐ Spanish
- ☐ Other ______________________

About Your ESRD Experience

Dialysis Facility Name: ______________________________

Dialysis Facility Phone Number: ______________________________

Name of Referring Staff Member (if applicable):______________________________

Years as an ESRD Patient/Family/Caregiver: ______

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

Are you able to attend 2 or more meetings by phone per year?

☐ Yes

☐ No

How often do you check your email?

☐ Daily

☐ 2-3 times per week

☐ Only when expecing important messages

☐ Don't have email

Please read about PAC member responsibilities at:
www.esrdnetwork10.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: NW10-PAC@qsource.org
Fax: 317-257-8291
Mail: Qsource ESRD Network 10
c/o Patient Services,
911 East 86th Street, Suite 202
Indianapolis, IN 46240

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