YOU CAN MAKE A DIFFERENCE

Are You a Dialysis Patient, Caregiver or Family Member?
Have you ever wished you could change things for the better at your dialysis facility?
Have you felt the call to give back but weren't sure how?

We invite you to join our Patient Advisory Committee!

Share your experience and unique expertise to help improve the care of dialysis patients and their families! **By joining, you become part of the governance structure of the End Stage Renal Disease Network and/or serve as a Subject Matter Expert on dialysis, working directly with your dialysis facility on various quality improvement projects. YOU** become the vital link to promoting better, patient-centered care.

What does a member of the Patient Advisory Committee Do?

You ultimately choose what level of involvement you are passionate about. From **attending webinars**, s**haring helpful tips and information with family and friends**, to serving as a **Patient Representative** at your Facility, assisting with **forming support groups and with patient care projects**, **participating in national conferences and calls**, to simply serving as an **advisor**, **there are many ways** your voice can count where it matters most!

How Do I Get Started?

If you are interested in joining the Patient Advisory Committee, simply complete and return the attached application. **Please fax the completed form to (216) 593-0101 or mail it to our office at 3201 Enterprise Parkway, Suite 210 Beachwood, Ohio, 44122. Questions about roles on the Committee? Call us at (216) 593-0001.**

"When I was younger, I met another young dialysis patient who had...given up and wanted to quit [treatment]...I told her about my experience as a child on dialysis and everything she had to look forward to. After our conversation, she decided to continue on dialysis and is still alive today."
-Vincent Fontanetta, Patient Advisory Committee Member

TO FILE A GRIEVANCE OR LEARN MORE ABOUT THE PATIENT ADVISORY COMMITTEE, PLEASE CONTACT US!

End-Stage Renal Disease Network of the Ohio River Valley
3201 Enterprise Parkway, Suite 210
Beachwood, Ohio 44122 | Tel: (216) 593-0001
Fax: (216) 593-0101 | Email: info@nw9.esrd.net
Web: newtork9.esrd.ipro.org

Patient Advisory Committee (PAC) Application

Please complete the information below

About You

I am (check one):	**____Patient ____Family/Caregiver ___Stakeholder**
I would like to participate in the role of (check one):	**____Member ____Facility Representative ____Advisor**
Name: First/Last	**Full Address:**
Primary Phone:	**Email Address:**
Cell Phone:	

I identify as: ___American Indian or Alaskan Native ___Asian ___Black/African American ___White ___ Other ___Native Hawaiian/Pacific Islander Ethnicity:___ Hispanic/Latino ___Not Hispanic/Latino

I mainly Speak: ___English ___Spanish

About Your ESRD Experience

Dialysis Facility Name:	**Name of Nominating Staff Member (if Applicable):**
CCN#:	
Dialysis Facility Phone Number:	**Nominating Staff Phone Number:**
Nominating Staff Email Address:	**Number of Years as a Dialysis Patient:**
	Are You on the Transplant Waitlist? Y / N

Current Treatment Type (Check One): ___In Center Dialysis: ____M/W/F or ____ T/T/S ___Peritoneal Dialysis ___ Home Dialysis ___Transplant. If Yes, How many years as a Transplant Recipient? ____

Previous Treatment Type(s) – Check All that Apply: ___In-Center Hemodialysis ___Transplant

___Peritoneal Dialysis ___Home Hemodialysis

Connecting with You

Preferred Method of Contact: ___Phone ___E-mail __Text Message	**How often do you check your e-mail? ___Daily ___Never ___2-3 times per week ___1 time per month**
I agree to receive text messages to connect: Y / N	**Are you able to travel for in-person meetings? Y / N**

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

☐ **I have read and understand the PAC member responsibilities and participation/membership policy and agree to fulfill them to the best of my ability.**

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3201 Enterprise Parkway, Suite 210 | Beachwood, Ohio 44122

To file a grievance, please contact us: IPRO End-Stage Renal Disease of the Ohio River Valley: Patient Toll Free: (844) 819-3010 | Phone: (216) 593-0001 | Fax: (216) 593-0101 | Email: info@nw9.esrd.net | Web: newtork9.esrd.ipro.org

PATIENT ADVISORY COMMITTEE (PAC)
PARTICIPATION AND CONFIDENTIALITY AGREEMENT

The Centers for Medicare & Medicaid Services (CMS) has contracted with the End Stage Renal Disease (ESRD) Network of the Ohio River Valley (Network 9) to promote education and resources to the ESRD patients and providers.

In order to support this endeavor, Network 9 maintains a PAC comprised of members, representatives and chairpersons for the purposes of lending perspective and giving feedback to the Network. The committee will be represented by peritoneal dialysis patients, hemodialysis patients, and transplant recipients, Care Partners and/or Family Members that represent all regions of Indiana, Kentucky and Ohio. The Network's Community Outreach Coordinator will coordinate and supervise the committee.

While serving on PAC, I may have access to confidential and proprietary information, as well as protected health information (PHI). This may include information related to patients and their treatment. I must safeguard the confidentiality of PHI which is subject to Federal and State laws as well as certain privacy and security regulations pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

I understand that I must keep this information in strict confidence and can only access this confidential and proprietary information to the extent required to participate in the PAC. I will not retain such information or any copies thereof or disclose it to third parties or use it for any purpose other than the authorized function, service or activity assigned to me. I also agree that I will not now or at any time in the future, either directly or indirectly divulge, disclose, or communicate in any manner whatsoever to any person not employed or affiliated with the PAC any confidential or proprietary information that I obtain during the course of my participation without the prior written consent of ESRD Network 9.

I understand that IPRO takes its obligation to protect patient information, including my personal health information, very seriously. As an IPRO PAC member, I understand that I am also obligated to protect patient information. In the event that I breach this participation and confidentiality agreement, I understand that IPRO may terminate my participation in the PAC. I also acknowledge that IPRO has advised me that, under Federal law, violations of confidentiality requirements may lead to fines from $100 per violation to $1,500,000 and up to ten years imprisonment.

I also consent to and authorize ESRD Network 9 to use my name and image on their website: esrd.ipro.org, in Network social media, in materials and other forms of communications. I understand that I will not receive any compensation for this. I give permission for my name, e-mail address and telephone number to only be given to my Regional PAC representatives, whom I serve as advisor to for direction. It is understood that the Network will not share any further information without my consent.

By signing this participation and confidentiality agreement, I agree to actively participate in the PAC as a PAC Chairperson, Member or Representative, and I agree to all of its terms and conditions.

Signature	**Print Name**	**Date**
_____	_____	_____

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