Quality Insights
Renal Network 5

# Patient/Family/Caregiver Subject Matter Expert Agreement Form

| About You | |
|---|---|
| I am (check one): ❑ Patient ❑ Family/Caregiver ❑ Stakeholder | |
| Name (First, Last): | |
| Address: | |
| City, State, Zip: | |
| Primary Phone: | |
| Email Address: | |
| I identify as:<br>❑ American Indian or Alaska Native<br>❑ Asian<br>❑ Black/African American<br>❑ Native Hawaiian or Other Pacific Islander<br>❑ White<br>❑ Other | I identify myself as<br>❑ Hispanic/Latino ❑ Not Hispanic or Latino<br><br>I mainly speak:<br>❑ English ❑ Spanish ❑ Other: _____ |
| **About Your ESRD Experience** | |
| Dialysis Facility Name: | |
| Dialysis Facility Phone Number: | |
| Number of Years as a Dialysis Patient _____ | Current Treatment Type: (check one)<br>❑ In-Center Hemodialysis: M/W/F or T/T/S<br>❑ Peritoneal Dialysis ❑ Home Hemodialysis<br>❑ Transplant; number of years as a recipient _____ |
| Are you on a transplant waitlist? (circle one)<br>❑ Yes ❑ No | Previous Treatment Types: (check all that apply)<br>❑In-Center Hemodialysis<br>❑Peritoneal Dialysis ❑Home Hemodialysis ❑Transplant |
| **Connecting With You** | |
| Preferred Method of Contact: ❑ Phone ❑ Email ❑ Mail | |
| How often do you check your email (check one):<br>❑ Daily<br>❑ 2-3 times/week<br>❑ Only when expecting important messages<br>❑ I don't have email | |
| Are you able to travel out of state for face- to-face meetings? ❑ Yes ❑ No | |
| Are you able to attend 2 or more meetings by phone per year? ❑ Yes ❑ No | |

**Don't forget to complete the other side! ☺**


**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 Network 5 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.

_____ _____

Signature Date

## Return this form to:

Quality Insights Renal Network 5
300 Arboretum Place, Suite 310
Richmond, VA 23236
Fax: 804.320.5918

To file a grievance, please contact Quality Insights Renal Network 5 at 1-866-651-6272, marc@nw5.esrd.net, 300 Arboretum Place, Suite 310, Richmond, VA 23236, or www.esrdnet5.org.