Patient Advisory Committee (PAC) Application Form

Please complete the following information to participate on the Network Patient Advisory Committee (PAC)

About You		
I am (check one):	____Patient ____Family/Caregiver	
I would like to participate in the role of **(check one)**	____ Member _____Facility Representative (must be nominated by facility)	
Name (First, Last)		
Address		
City, State, Zip		
Primary Phone		I agree to receive Text Messages ____Yes ____ No
Cell Phone		
Email Address	**Date of Birth** ____/____/_____	
I identify as:	____American Indian or Alaska Native ____Asian ____ Black/African American ____Native Hawaiian or Other Pacific Islander ____White/Caucasian ____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 Nominating Staff Member		
Nominating Staff Member Phone / Email Address		
Number of Years as a Dialysis Patient		
Current Treatment Type: (check one)	____In-Center Hemodialysis: ____M/W/F or ____ T/T/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?	____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?	____Yes ____ No	
Are you able to attend 2 or more meetings by phone per year?	____Yes ____ No	

Please send both the **PAC Application Form** and **PAC Participation and Confidentiality Form** by U.S. mail or fax to:

IPRO ESRD Network of New England
1952 Whitney Avenue, 2nd Floor, Hamden, CT 06517
Fax 203-389-9902

DO NOT EMAIL THE COMPLETED FORM, AS IT WILL CREATE A SECURITY BREACH.

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 New England (Network 1) to promote education and resources to the ESRD patients and providers.

In order to support this endeavor, Network 1 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 the New England area (CT, MA, RI, NH, ME, VT). 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 1.

I understand that violations of confidentiality requirements may, under Federal law, lead to a fine from $100 per violation to $1,500,000 and up to ten years imprisonment.

In the event I breach this participation and confidentiality agreement, I understand that IPRO may terminate my participation in the PAC, which does not limit IPRO's right to seek any other remedy under the law.

I also consent to and authorize ESRD Network 1 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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