HSAG HEALTH SERVICES ADVISORY GROUP
ESRD Network 15

Patient Subject Matter Expert Application Form

Please complete the following information for consideration to participate on the Network Patient Advisory Council (PAC) and/or as a Network Patient Subject Matter Expert.

About You	
I am a (*Please check one*):	☐Patient ☐Family/Caregiver ☐Stakeholder
Name (*Please provide First and Last*):	
Address:	
City, State, Zip:	
Primary Phone:	
Email Address:	
I identify as:	☐American Indian or Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other
Ethnicity—I identify 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 Referring Staff Member (*Must be included if staff member is referring candidate*):	
Number of Years as a Dialysis Patient	
Current Treatment Type: (*Please 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: (*Please 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: (*Please 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 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 my responsibilities to the best of my ability.

☐ I authorize Network 15 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.

Applicant Signature: _____ Date:_____

Staff Signature: _____ Date: _____
(*If Applicable*)

Please submit this completed form to Network 15 by either of the following methods:

- Fax: 303.860.8392
- Mail: 3025 South Parker Road, Suite 820
  Aurora, CO 80014

If you have any questions, please contact the Network at 1.800.783.8818.

Note: If we receive more applications than there are available SME positions, we may retain your application for use at a later date, as additional SME participants are needed.

This material was prepared by HSAG: ESRD Network 15, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.
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