



PFAC

Patient & Family  
Advisory Council

**PFAC**  
**Patient, Family & Caregiver**  
**Subject Matter Expert (SME)**

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*Application*

**2021 - 2026 Edition**



Quality  
Insights

Renal Network 3

# QIRN<sub>3</sub> PFAC - Application

<b>Applicant is:</b>	<input type="checkbox"/> In-Center Dialysis Patient <input type="checkbox"/> Home Hemodialysis Patient <input type="checkbox"/> Family/Caregiver <input type="checkbox"/> Peritoneal Dialysis Patient <input type="checkbox"/> Transplant Patient
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Name \_\_\_\_\_

Mailing Address \_\_\_\_\_ City, State, and Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

<b>I identify as:</b>	<b>I identify myself as Hispanic/Latino:</b>
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

<b>I mainly speak</b>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ I'm also fluent in: _____
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## About Your Dialysis Experience

Name of Your Dialysis Center \_\_\_\_\_ Name of Facility Staff Referring Candidate (if applicable) \_\_\_\_\_

<b>Dialysis Schedule:</b>	<input type="checkbox"/> M/W/F <input type="checkbox"/> T/T/S <input type="checkbox"/> N/A Time: _____            Time: _____
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Number of years as a dialysis patient:	If you are transplant patient, number of years as a transplant recipient:	Are you on a transplant waitlist?	Previous Treatment Types: (check all that apply)
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a	<input type="checkbox"/> In-Center Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Hemodialysis <input type="checkbox"/> Transplant

**Please read the following statements (all must be checked to be considered):**

<input type="checkbox"/> I have read the PFAC member responsibilities and participation / membership policy and agree to fulfill them to the best of my ability.	<input type="checkbox"/> I authorize QIRN3 and my dialysis center (if applicable) to utilize my name, address and email for specific PFAC communications.	<input type="checkbox"/> I further authorize QIRN3 to use my name and image where necessary, recording of PFAC meetings, reports to CMS and other business documentation.
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**Candidate's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Facility Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Conflict of Interest Disclosure Form & Confidentiality Agreement

List all *relationships* you or *family members* have with:

- (1) health care providers,
- (2) organizations that do business with Quality Insights,
- (3) competitors of Quality Insights; or
- (4) government agencies that regulate or contract with Quality Insights.

*“Relationship”* means:

- (1) employment, ownership or other financial interest; or
- (2) service as a director, officer, partner or manager.

*“Family member”* means spouse, children, siblings and anyone living in your household.

Entity	Nature of Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I certify that the information provided above is accurate and complete to the best of my knowledge. I agree to act in the best interests of Quality Insights in performing my job duties and to not let any financial, personal or outside professional interests interfere with this obligation. I will refrain from participating in Quality Insights’ consideration of any transaction or other matter in which I or a family member have a financial, personal or outside professional interest. Neither I nor a family member will solicit or accept any gift, gratuity, payment or anything of value from anyone who does or seeks to do business with Quality Insights or who is reviewed by Quality Insights. I agree to keep confidential any non-public or privileged information and not to use such information for personal gain. I agree to provide an updated conflict of interest disclosure form to Quality Insights whenever a material change occurs to the information I have provided on this form.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Please print your name

**Please submit completed application via fax to  
Yessi Cubillo 609-490-0835  
ycubillo@qualityinsights.org  
or postal service  
PO Box 845 Hightstown, NJ 08520**

# Contact Information



Quality  
Insights

Renal Network 3

PLEASE  
FAX OR MAIL  
ALL PATIENT ADVISORY COMMITTEE  
MEMBERSHIP APPLICATIONS  
& AGREEMENTS TO

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**Fax:** (609)490-0835

**Mail:** Quality Insights Renal Network 3  
PO Box 845  
Hightstown, NJ 08520

**Email:** [ycubillo@qualityinsights.org](mailto:ycubillo@qualityinsights.org)

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**Yessi Cubillo**

*Patient Engagement Specialist*

(609)490-0310 (Ext. 2431)

[ycubillo@qualityinsights.org](mailto:ycubillo@qualityinsights.org)

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**Patient Toll Free Number:** 1-888-877-8400

[www.qirn3.org](http://www.qirn3.org)