Quality Insights
Renal Network 5

# Kidney Connection:
# A Patient to Patient Peer Mentoring Program
# Application

The Centers for Medicare & Medicaid Services (CMS) collects information from people with Medicare to improve their customer experience. Executive Order 12862 authorizes federal agencies, like CMS, to collect information when it is being used to improve the quality of service and satisfaction that they want people with Medicare to experience.

Your response to this application is voluntary. However, should you choose not to respond, it may affect CMS's efforts to ensure people with kidney disease are given the opportunity to participate in a peer mentoring program where a patient peer shares information and supports a newly diagnosed patient with kidney disease. The responses provided in this information collection will be used only for the Kidney Connection Patient Peer Mentoring Program to pair peer mentors (patients providing information and experiences) to mentees (patients seeking information and experiences).

Thank you for your interest in the Kidney Connection Patient to Patient Peer Mentoring Program. The information that you provide on this application will help pair you with your peer and will only be used for this program. Please answer all the questions on this form and fax your completed application to Renee Bova-Collis at 804-320-5918. If you have questions about the application or the program, please call Renee Bova-Collis at 866-651-6272 Ext. 2705.

| **I WOULD LIKE TO:** | ☐ **BECOME A MENTOR** | ☐ **BE PAIRED WITH A MENTOR** |
|---|---|---|

**Patient Information**

☐ Mr. ☐Mrs. ☐ Ms. ☐Other: _____

First Name: _____ Last Name: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

**Tell Us About Yourself**

Select your age range:

☐ 18–24 years ☐ 25–34 years ☐ 35–44 years

☐ 45–54 years ☐ 55–64 years ☐ 65+ years

How long have you been an ESRD/dialysis patient?

☐ Less than 1 year ☐ 1–3 years ☐ 3–5 years ☐ 5+ years

Current treatment modality:

☐ In-center hemodialysis ☐ Home hemodialysis ☐ Nocturnal dialysis

☐ Transplant ☐ Home peritoneal dialysis

Previous treatment modality experience *(select all that apply)*:

| *Modality* | *Years of experience* |
|---|---|
| ☐ In-center hemodialysis | |
| ☐ Transplant | |
| ☐ Nocturnal dialysis | |

| *Modality* | *Years of experience* |
|---|---|
| ☐ Home hemodialysis | |
| ☐ Home peritoneal dialysis | |

**Mentoring Preferences**

I would like to be paired with a:

☐ Male ☐ Female ☐ No specific preference

Topic(s) of Interest:

☐ New to dialysis ☐ Home dialysis ☐ Transplant ☐ ESRD Overview

☐ Other_____

Preferred Language(s):

☐ English ☐ Spanish ☐ Other: _____

☐ Chinese ☐ French

I would like to connect with mentor/mentee via *(select all that apply)*:

☐ In-person ☐ Phone Call ☐ Email ☐ Zoom ☐ Facetime

☐ Other: _____

How comfortable are you with using a computer, internet, iPad/tablet, smartphone or other devices:

☐ a. Very comfortable, could teach a class

☐ b. Somewhat comfortable, need some assistance

☐ c. Hardly know the basics, enough to get on and off the Internet

☐ d. Not comfortable at all, I need one to one assistance

**I agree that I have completed this application to be considered for the Kidney Connection Patient to Patient Peer Mentoring Program and I understand that information will only be used to pair patient peer mentors and mentees.**

Signature: _____ Date: _____

**Thank you for completing application. Please ask your facility to complete the following section and help you fax your application to Renee Bova-Collis at 804-320-5918.**

**FACILITY & STAFF INFORMATION**

*SECTION TO BE COMPLETED BY FACILITY STAFF*

| CMS Certification Number (CCN) | Facility Name |
|---|---|
| | |

Referring Staff Title

☐ Facility Administrator ☐ Clinic Manager ☐ Social Worker

☐ Nurse ☐ Nephrologist ☐ Other: _____

First Name: _____ Last Name: _____

Phone: _____ Email: _____

Form Updated: 6/2022