Quality Insights
Renal Network 3

Kidney Connection:
A Patient to Patient Mentoring Program
Application

Thank you for your interest in the Kidney Connection Patient to Patient 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 Yessi Cubillo at 609-490-0835. If you have questions about the application or the program, please call Yessi Cubillo at 609-490-0310 Ext. 2431.

I WOULD LIKE TO:	☐ **BECOME A MENTOR**	☐ **BE PAIRED WITH A MENTOR**	I know the name of the mentor I would like to be paired with: _____

Tell Us About Yourself

☐ Mr. ☐Mrs. ☐ Ms. ☐Other: _____

First Name: _____ Last Name: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

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:

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

Preferred Language(s):

☐ English ☐ Spanish ☐ Other: _____

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 Mentoring Program. I understand this information will only be used to pair patient mentors and mentees.

Signature: _____ Date: _____

Thank you for completing the application. Please ask your facility staff to fill out the following section and help you fax this application to Yessi Cubillo at 609-490-0835.

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: _____

☐ Our facility doesn't have a mentor. Patient mentee needs to be paired with a mentor from the program.

☐ Our facility has an active patient mentor in this program.

Patient mentee will be paired with our mentor named: _____

☐ Our facility has an active patient mentor but mentee needs to be paired with a different mentor.

☐ Other: _____

Form Updated: 3/2023