HSAG HEALTH SERVICES ADVISORY GROUP
ESRD Networks 7, 13, 15, 17, 18

2023 Peer-to-Peer Agreement Form

For Clinic Staff

Name of current dialysis or transplant facility:	
Facility CCN:	
Facility phone number:	
Name of referring staff member (if applicable):	

About You

Name:			
Date of Birth:			
ESRD Network:	Network 7: Florida Network 13: Arkansas, Louisiana, Oklahoma Network 15: Arizona, Colorado, Nevada, New Mexico, Utah, Wyoming Network 17: American Samoa, Guam, Hawaii, Northern California, Northern Mariana Islands Network 18: Southern California		
Mailing address:			
Home phone:		Cell phone:	
Email:			
I identify myself as:	American Indian or Alaska Native Asian Black/African American Native Hawaiian or other Pacific Islander White Other		
I identify myself as:	Hispanic or Latino Not Hispanic or Latino		
I speak:	English Spanish Other (*please specify*):		

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

About Your End Stage Renal Disease (ESRD) Experience

Number of years as a dialysis patient?			
Current treatment type? *(Check one)*	In-center hemodialysis Home hemodialysis Peritoneal dialysis Transplant		
Dialysis Schedule (if applicable)	M/W/F	T/Th/Sat	Shift time:

Previous treatment type(s) (check all that apply)

In-center hemodialysis	From	To
Home hemodialysis	From	To
Peritoneal dialysis	From	To
Transplant	From	To

Are you currently on a transplant waitlist?	Yes	No

Connecting With You

What types of social media do you use?	Facebook Instagram Twitter TikTok None

Area of Interest

I am interested in these topics *(Check all that apply)*:

	Transplant		Adjustment to dialysis
	Home modalities		Managing fluid
	Managing diet		Mental health

I am interested in being (Check one or the other):

	Mentor		Mentee

I would prefer to be paired (Check one)

	Male		Female		No preference

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Agreement

Please read the following statements:

- **I authorize my ESRD Network to use my name and e-mail address for the Network-specific communications.**
- **I further authorize HSAG to use my name where necessary in meeting minutes and in listing Peer Mentors in reports to the Centers for Medicare & Medicaid Services (CMS).**
- **If my contact information changes or I am unable to participate, I agree to notify the Network.**

I ____ (print name) agree to participate in the Peer-to-Peer Program for the ESRD Network. I give my permission for the Network to utilize photos and videos of me in print or electronic form for any lawful reason, with or without my name, and for the Network partners to use my image in print or electronic form, provided I am given prior notice. I have the right to submit a written request to cancel my approval at any time for any reason (except for materials that have already used my image), refuse signature of this form, without consequence, and receive a copy of this form. I understand that my image may be used in publicity, advertising, and web content. My approval will not affect any service the Network may provide me, and my approval will last 20 years from the day I sign it. The Network will not be able to protect my image once it is public, and I will not be paid for allowing Network to use my image.

I have read and understand the above:

Sign		**Date**	

Thank you for agreeing to volunteer for the Network's Peer-to-Peer Program. Your work with us is valued and your time and effort are greatly appreciated by the Network and CMS.

Please submit this completed form to Network by fax or mail:

- Fax:
- Mailing address: 3133 East Camelback Road, Suite 140 Phoenix, AZ, 85016-4545

If you have any questions, please contact your Peer Mentor Program Champion:

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