Kidney Connection: A 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 Peer Mentoring Program. Please answer all the questions on this form and submit your completed application via fax to (516) 231-9767.

The information that you provide on this application will help pair you with your peer and will only be used for the Peer Mentoring Program. If you have questions about the application, please call Danielle Andrews, MPH, MSW, GCPH, Project Manager/Health Equity Specialist at (516) 209-5549.

Contact Information

First Name: _____ Last Name: _____

City: _____ State: _____ ZIP Code: _____

Email: _____ Phone Number: _____

Is this a smart phone? (Yes/No) _____

How do you prefer to be contacted about the Kidney Connection Patient Peer Mentoring Program?

(Circle one.) ☐ Email ☐ Phone ☐ No Preference

What is the best day and time to reach you about the Kidney Connection Patient Peer Mentoring Program?

Time of Day	Monday	Tuesday	Wednesday	Thursday	Friday
Morning: 8 a.m.–12 noon ET					
Afternoon: 1 p.m.–4 p.m. ET					

Tell Us About Yourself

Select the age range that best matches your age. (Circle one 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? (Circle one answer.)

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

Current treatment modality: (Circle one modality.)

In-center hemodialysis Home (hemodialysis or peritoneal dialysis) Transplant

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If you are an in-center or home dialysis patient, please tell us the following:

Facility Name: _____ City: _____ State: ___ ZIP Code: _____

I would like to be a: (Circle one.) ☐ Mentor ☐ Mentee

Mentor: I would like to be paired with a: (Circle one.) Male mentee Female mentee No preference

Mentee: I would like to be paired with a: (Circle one.) Male mentor Female mentor No preference

Topic Interest: (Circle one.) New to dialysis Home dialysis Transplant ESRD Overview

Please identify your interests, hobbies, commitments, and activities, and give us any other information you feel will help us pair you with another patient: (Circle as many that apply.)

Reading/Podcasts Traveling Movies/Television Sports Outdoor Activities (hiking, fishing, hunting)

Gardening Arts/Crafts Cooking/Baking Dance/Band/Music/Choir Photography

Other: _____

Preferred Language: (Circle one.)

English Spanish Chinese French Other: _____

Do you have access to the Internet? (Yes/No) _____

Which of the following communication applications are you familiar with? (Circle all that apply.)

Zoom Google Voice

Please Answer Each Statement With the One Best Response

Statements	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Usually I am very calm and relaxed in conversations.					
I have no fear of speaking up in conversations.					
Usually I am very tense and nervous in conversations.					
I feel very relaxed when talking to a new person.					
I am afraid to speak up in conversations.					
I feel very nervous when talking with a new person.					

I agree that I have completed this application to be considered for the Kidney Connection 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 the Patient Peer Mentoring Program application. Please ask your facility to help you fax your application to (516) 231-9767.

This material was prepared the End Stage Renal Disease National Coordinating Center (ESRD NCC) contractor, 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 nor imply endorsement by the U.S. Government.
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