**PATIENT & FAMILY PARTNERSHIP COUNCIL APPLICATION**

Your Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street Address, City)

Your phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient‘s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your relationship to the patient:

€ Spouse/Significant Other

* Parent € Child
* Friend € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s care setting(s) – *please mark all that apply*:

* Home (any private residence)

Approximate # of days = \_\_\_\_\_\_\_

* Long-term care facility (e.g. assisted living, nursing home)

Approximate # of days = \_\_\_\_\_\_\_

* Agrace Inpatient Unit

Approximate # of days = \_\_\_\_\_\_\_

Overall how would you rate your Agrace experience?

€ Excellent € Very Good € Good € Fair € Poor

Areas of interest based on your experience – *please mark all that apply*:

* Medication management € Pain control
* Communication € Patient/family education
* Falls € Transitions from one care setting to another
* Marketing & advertising € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Scheduling Flexibility:

* I have some flexibility between 8 a.m. and 5 p.m. and could attend meetings during this time.
* I can only attend meetings after 5 p.m.

Please provide a brief summary of your Agrace experience (bright spots, frustrations, etc.):

**Please return to:**

 **Agrace**

 **Attn: Dawn Ferengo**

 **5395 E. Cheryl Parkway**

 **Madison, WI 53711**

 **or email to:**

 **dawn.ferengo@agrace.org**