HSHS Holy Family Hospital

FAMILY AND PATIENT ENGAGEMENT COUNCIL APPLICATION

*Name of applicant(s):*_____ *Home Phone:*_____

Preferred contact person (if applying as a couple): _____

*Home Address:*_____ *Cell/Work Phone(s):* _____

*City/State/Zip:*_____ *Best times to reach you:* _____

Email(s): _____ *Preferred method of contact:* _____

Occupation(s): _____ *Languages spoken at home:*_____

How did you hear about this opportunity? _____

Name of patient or loved one with health needs/experience: _____

*Patient's DOB:*_____ *Patient's Relation to you:* _____

*Patient's Primary Diagnoses:*_____ *Dates of First and Most Recent Admission:*_____

Would you be able to participate in monthly meetings for a term of ***ONE YEAR****?* □ *Yes* □ *No*

Would you need assistance with transportation, childcare, or other accommodations? □ *Yes* □ *No*

If yes, please explain:

_____

_____

Patient and Family Engagement Council will take place quarterly (four times per year).

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Which HSHS Hospital service has your family used? Please check all that apply below. Check "Past Year" if you have used the service within the past year or "Ever Received", if you have ever used the service in the past.

We have received health care services at the following HSHS Hospital (check below):

☐ ***HSHS Holy Family Hospital Greenville*** ☐ ***Other HSHS ministry _____***

Past Year	***Ever Received***	***Services***
		Behavioral Health Services
		Cardiology
		Ear, Nose, Throat
		Endocrine/Diabetes
		Gastroenterology
		Hematology/Oncology
		Nephrology
		Neurology
		Neurosurgery
		Orthopedics
		Outpatient Clinic, Please Specify:
		Outpatient Lab
		Outpatient Surgery
		Pain Management
		Psychology/Psychiatry
		Pulmonology
		Radiology (X-Ray, MRI, CT, Ultrasound)
		Respiratory
		Surgery
		Other, Please Specify:

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Tell us a little about yourself and your family:

Why would you like to be a member of the Patient and Family Engagement Council?*

What do you feel you could bring to the Patient and Family Engagement Council?

****Please be aware that the Patient and Family Engagement Council is not a support group. It is a working group to support patient and family-centered care.***

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Conditions of Volunteer Services (Please read before signing):

We will contact you by phone or e-mail if you are selected for an on-site interview to learn more about your interests, and discuss the opportunity to become a member of the Patient and Family Engagement Council. In order to participate, you must meet our routine volunteer requirements. You will be required to pass a criminal background check, submit immunization records and receive any necessary immunizations, undergo HIPAA training and sign a confidentiality agreement. If you are unable to fulfill these requirements, you will not be eligible to serve on the Patient and Family Engagement Council.

I certify that the statements made in this application are true and correct and have been given voluntarily. I understand that I will not be paid for my services as a volunteer member of the Patient and Family Engagement Council. I agree to abide by the guidelines of Volunteer Services, to respect patient confidentiality, and to uphold the standards of Hospital Sisters Health System. All information contained on this form is considered confidential and is intended for use by the HSHS Patient and Family Engagement Council Selection Committee only.

*Applicant's Signature:*_____ *Date:*_____

Please return completed application to:

HSHS Holy Family Hospital
HSHS Patient and Family Engagement Council
Attention: Teresa Cornelius
200 Health Care Drive
Greenville, IL 62246
P: 618-664-1230
Email: Teresa.Cornelius@hshs.org