COMMUNITY HEALTH MENTOR PROGRAM

Thank you for your interest in being a Community Health Mentor! This is an opportunity for you to share your healthcare story with future health professional students and guide the students as they ask questions about your journey. Your team(s) are dependent on your availability and our current program needs.

IN PERSON MEETINGS

Meetings to be held in person with an interprofessional team of students in healthcare professions including a Medical Doctor (UA), Physician Assistant (NAU), Physical Therapist (NAU), Occupational Therapist (NAU), and a one-time visit from a Nutrition student (ASU).
***Meetings to always be held Wednesday afternoons between 1-5pm.**

DATE	TOPIC
Wed 04/25/2018	Medical History & Medication Management
Wed 05/30/2018	Community Barriers
Wed 07/18/2018	Functional Assessment (ADLs and IADLs)
Wed 10/24/2018	Nutrition
Wed 11/28/2018	Home Needs Assessment
Wed 01/30/2019	Advance Directives
Wed 03/13/2019	Advocacy and Celebration at our Downtown Phoenix Campus

PHONE CALLS

Phone calls to be scheduled with an interprofessional team of student healthcare professionals including a Medical Doctor (UA) and Nursing (UA).
Some teams will include Social Work (ASU) and Pharmacy (UA).
***Meetings to scheduled during the time frame below:**

DATE	TOPIC
To occur in Summer, Fall, and Winter	A variety of topics will be covered.

CONTACT US

Program Coordinator
Claire Pascavis
Office: (602) 827-2609
PBC-mentor@email.arizona.edu
Fax: (602) 827-2397 (Attn: Claire Pascavis)

Program Director
LeeAnne Denny, M.D.
Mobile: (480) 335-7851

University of Arizona
College of Medicine – Phoenix
Health Sciences Education Building
435 North 5th St.
Phoenix, Arizona 85004

Website
Phoenixmed.arizona.edu/community-mentor

MENTOR ELIGIBILITY

Mentors must meet all these requirements:

- 18 years of age or older
- Have at least one chronic medical condition such as heart disease, high blood pressure, lung disease, diabetes, kidney disease or arthritis
- Able to make a 2-year commitment
- Must have a Primary Care Provider
- Must be available on Wednesday afternoons
- Must be able to speak on phone 30 minutes five times per year
- Must live or be able to meet the students within 20 minutes of downtown Phoenix

SHARE ABOUT THE MENTOR PROGRAM

If you have friends or family members who might be interested in being mentors in our Community Health Mentor Program and meet the eligibility requirements, please have them reach out to us! We are always looking for new mentors!

Email:
PBC-mentor@email.arizona.edu

Website:
Phoenixmed.arizona.edu/community-mentor

ELECTRONIC PAPER WORK

If it would be easier for you to fill out electronic copies of this paperwork,
please contact us at PBC-mentor@email.arizona.edu
or call Claire at (602) 827-2609.

Community Health Mentor Guidelines
Mentor Copy - Please Keep for Your Records

1. The Community Health Mentor Program requires a 2-year commitment. A team of 2-6 students in health professions will meet with you approximately every 6 weeks during the first year to complete assignments and discuss your experiences with healthcare. During the second year of the course, the students will meet with you by phone less frequently.
2. You will receive a schedule of dates and topics of the Community Health Mentor Visits for the year.
3. Students will do visits in groups; no visits are to occur when a student is alone.
4. Students will complete their visits during the day on weekdays on the scheduled dates. No nighttime or weekend visits are permitted.
5. Visits will occur in your home unless otherwise arranged. Some visits can be scheduled at community centers, coffee shops, or other locations that are agreeable to you and all members of the team.
6. Students will immediately notify 911 in medical and safety emergencies as well as notify the coordinator for the Community Health Mentor Program. Your emergency contact person will then be notified by the coordinator.
7. Students cannot offer medical or rehabilitation treatment or advice. If you have any questions about your medical condition, you must contact your primary care physician.
8. Students cannot provide or accept transportation under any circumstances.
9. Students cannot give or accept gifts, gratuities, or loans from you or any member of your family. Students may not purchase items for you or your family.
10. Students are expected to act in a professional, courteous, and ethical manner at all times. If you feel the student is not acting appropriately, please contact Claire Pascavis, Program Coordinator, at 602-827-2609.
11. Mentors are expected to act in a professional and courteous manner at all times.
12. The Health Insurance Portability and Accountability Act (HIPAA) does not directly apply to the Community Health Mentor Program as students are not providing medical care. However, students must maintain the privacy and confidentiality of your information, including your health-related information. If you feel that there has been any kind of breach of your privacy or if you feel your information has been compromised in any way, please call Claire Pascavis, Program Coordinator, at 602-827-2609.
13. If you are unable to meet with your team of health professions students on the scheduled day and time, please contact Claire Pascavis, Program Coordinator, at 602-827-2609 or PBC-mentor@email.arizona.edu so she can notify your students and arrange an alternate assignment.
14. The Community Health Mentor Program may periodically schedule a visit with you to discuss in person any feedback you have.
15. Students will be asking you questions about your medical and social history, your community, insurance coverage, home safety, nutrition, and other topics. This information will be collected in order to complete their assignments and to achieve their learning objectives. You are not required to answer any questions that you do not feel comfortable with and please feel free to let the students know that you are not comfortable with answering any particular questions.
16. Mentors are expected to complete feedback forms twice annually in regards to the Community Health Mentor Program.
17. If you have any questions or concerns, please feel free to contact Claire Pascavis, Program Coordinator, at 602-827-2609 or by email at PBC-mentor@email.arizona.edu.

I have received a copy of the Community Health Mentor Information Sheet. I have read and agree to abide by the conditions set forth by this program. I agree to participate as a Community Health Mentor in the Community Health Mentor Program and I understand that I may withdraw from participation at any time. If I wish to withdraw from participation, I agree to contact Claire Pascavis, Program Coordinator, at 602-827-2609.

Mentor Signature_____ **Date**_____

Mentor Printed Name _____

Consent to Participate in the Community Health Mentor Program

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I, _____, consent to participate in the Community Health Mentor Program, a collaboration between the University of Arizona, Northern Arizona University, and Arizona State University. I understand that by participating in this program I am agreeing to meet with a group of interprofessional healthcare students approximately every six weeks for one year for a total of eight visits. I understand I will continue to meet with students by phone during the second year of the Community Health Mentor Program for a total of three phone visits. I understand I will be asked to abide by the protocols outlined in the Community Health Mentor Guidelines.

I grant permission for the students to conduct home visits to complete the goals and objectives of this program. I grant permission for the students and course director to share information related to our mentoring visits with my Primary Care Provider. I understand I may refuse to allow specific information be shared with my Primary Care Provider by specifying this to the Program Director. I understand the students are still in training and cannot offer medical or rehabilitation advice.

I understand consent for this program is voluntary and does not waive any of my rights to confidentiality. I understand I will be asked a variety of questions related to my health, healthcare, and other areas that may involve providing personal or sensitive information. I understand I may refuse to answer any question I do not feel comfortable with. I understand my participation is completely voluntary and I can withdraw my participation at any point during this program. If I wish to withdraw from participation, or if I have any questions or concerns about my participation, I agree to contact Claire Pascavis, Program Coordinator, at 602-827-2609. I understand the program may end my participation anytime at their discretion.

I have read this document, or have had this document and the Community Health Mentor Guidelines read to me in their entirety, and I understand fully the content and agree to participate in the Community Health Mentor Program. I understand this consent is in effect as of the date of my signature and is valid for 2 years. I acknowledge I have received a copy of this form and the Community Health Mentor Guidelines.

Mentor Signature: _____

Mentor Printed Name: _____

Date:_____

DATE: _____ **Program Copy - Please Complete & Return**

COMMUNITY HEALTH MENTOR CONTACT INFORMATION

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr.		
Name:		
Best Contact Phone:	**Alternate Phone:**	
Email:		
Address:		
City:	**State: AZ**	**ZIP Code:**

EMERGENCY CONTACT INFORMATION

Name:		
Phone:	**Relationship:**	
Address (if different):		
City:	**State:**	**ZIP Code:**

PERSONAL INFORMATION

Primary Care Provider:	**Phone:**	
Chronic Medical Condition(s):		
Gender:	**Date of Birth:**	**Are you a Veteran?** ☐ **Yes** ☐ **No**
Ethnicity:	**What is your Primary Language?**	
How did you first hear about our program?		

MEETING SETTINGS

****MEETINGS WITH OUR STUDENTS MUST TAKE PLACE WITHIN 20 MINS OF DOWNTOWN PHOENIX**

Where do you plan to meet the students? ☐ **My Home** ☐ **My Work** ☐ **Public Location** ☐ **I am only available for phone calls with students**		
Work/Public Location Name (within 20 mins):		
Address:	**City:**	**Zip:**
What is the maximum number of students you can accommodate?		
LOCATION ACCESS/INFORMATION: (Gate code to sub-division, pets, special instructions, parking, etc.):		

Program Copies -

Please complete the Guidelines, Consent to Participate, and Contact Information forms

Please mail the completed forms to:

University of Arizona-College of Medicine Phoenix
Health Sciences Education Building
Attn: Claire Pascavis
435 North 5th Street
Phoenix, AZ 85004

To fill out electronic copies of this paperwork instead, please contact us at:
PBC-mentor@email.arizona.edu

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