

## 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.

### MEETINGS WITH STUDENTS

Meetings to be held in person with an interprofessional team of students in healthcare professions who are learning to be a Medical Doctor (UA), Occupational Therapist (NAU), Physical Therapist (NAU), Physician Assistant (NAU), and a one-time visit from a Nutrition student (ASU).

**\*Meetings will always be held Wednesday afternoons between 1:00pm-5:00pm.**

DATE	TOPIC
4/14/2021	Medical History
6/2/2021	Community Barriers
7/14/2021	Functional Activities
9/1/2021	Home Safety
10/6/2021	Nutrition
1/26/2022	Advance Directives
3/2/2022	Advocacy and Celebration

### CONTACT US

**University of Arizona Program Coordinator**

Bekah Petersen

(602) 827-2609

[PBC-mentor@email.arizona.edu](mailto:PBC-mentor@email.arizona.edu)

Fax: (602) 827-2397 (Attn: Bekah Petersen)

**Northern Arizona University Coordinator**

Sharon Martland

(602) 827-2450

[Sharon.Martland@nau.edu](mailto:Sharon.Martland@nau.edu)

**University of Arizona Program Director**

LeeAnne Denny, M.D.

[ladenny@email.arizona.edu](mailto:ladenny@email.arizona.edu)

**Community Health Mentor Program**

Health Sciences Education Building

435 North 5<sup>th</sup> Street

Phoenix, Arizona 85004

**Website**

[Phoenixmed.arizona.edu/community-mentor](http://Phoenixmed.arizona.edu/community-mentor)

## MENTOR ELIGIBILITY

Mentors must meet listed requirements to be eligible to participate:

- 18 years of age or older
- Have a disability or more than one chronic medical condition such as heart disease, high blood pressure, lung disease, diabetes, kidney disease, HIV, arthritis, etc.
- Have a Primary Care Provider
- Be available on Wednesday afternoons
- Live or be able to meet the students within 25 minutes of downtown Phoenix
- No current illicit drug use
- No active suicidal ideation or psychosis
- No history of violent behaviors (e.g., domestic violence, hate crimes, etc.)
- No history of stalking behaviors
- No history of sexual harassment or offenses

## SHARE ABOUT THE COMMUNITY HEALTH 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](mailto:PBC-mentor@email.arizona.edu)

**Website:**

[Phoenixmed.arizona.edu/community-mentor](http://Phoenixmed.arizona.edu/community-mentor)

**Interest Form:**

[Phoenixmed.arizona.edu/community-mentor/interest](http://Phoenixmed.arizona.edu/community-mentor/interest)

## TESTIMONIALS

“All in all, these mentors helped mold us from young medical students into full-fledged humanistic physicians with lessons on the real-world workings of health care that we will use in our practices forever and for that, we cannot be more thankful.”

— Haig A., Medical Student, Class of 2018

“I’m honored to be involved with this program. I know that we are supposed to be the mentor in this program, but I’ve learned so much. I hope you learned from us how to relate to people who have a condition or disability. I know that all of you will be great teachers, and I look forward to seeing you in the medical field having successful careers.”

— Don P., Community Health Mentor

## Community Health Mentor Contract

### Please Keep for Your Records

1. The Community Health Mentor Program requires a one-year commitment. A team of two-six students in health professions will meet with you approximately every six weeks during the first year to complete assignments and discuss your experiences with healthcare.
2. This is an educational program for healthcare students, as such, students are not licensed or prepared to provide care and cannot offer medical or rehabilitation treatment or advice. Therefore, I agree that I will not seek medical advice or opinions from the students. If I have any questions about my medical condition, I will contact my healthcare provider(s).
3. I acknowledge that my participation in this program as a mentor is completely voluntary and I have not been coerced to participate in any way.
4. Mentors are expected to act in a professional and courteous manner at all times and I agree to do so.
5. I meet the following eligibility requirements
  - 18 years of age or older
  - Have a disability or more than one chronic medical condition such as heart disease, high blood pressure, lung disease, diabetes, kidney disease, HIV, arthritis, etc.
  - Have a Primary Care Provider
  - Available on Wednesday afternoons from 1:00pm to 5:00pm
  - Live or be able to meet the students within 25 minutes of downtown Phoenix
  - No current illicit drug use
  - No active suicidal/homicidal ideation or psychosis
  - No history of violent behaviors (e.g., domestic violence, hate crimes, etc.)
  - No history of stalking behaviors
  - No history of sexual harassment or offenses
6. I agree I will notify the Program Coordinator if my eligibility changes at 602-827-2609 or [PBC-Mentor@email.arizona.edu](mailto:PBC-Mentor@email.arizona.edu)
7. I agree to the schedule of dates and topics of the Community Health Mentor Visits for the year as described in the Community Health Mentor Program brochure. If I am unable to meet with my team of health professions students on the scheduled day and time, I will immediately contact the Program Coordinator, at 602-827-2609 or [PBC-mentor@email.arizona.edu](mailto:PBC-mentor@email.arizona.edu). The students will be then be notified and an alternate assignment will be arranged.
8. I understand that due to the COVID-19 pandemic certain precautions and modifications to the program may occur to ensure my safety and the safety of the students participating.
  - Visits may be conducted remotely (i.e., via phone or zoom), OR
  - Masks may be required with visits taking place in a setting that allows for appropriate social distancing
9. I understand that in-person visits are conducted in groups and no visits are to occur when a student is alone.
10. I understand that visits will occur in my home unless otherwise agreed to with the students. Some visits can be scheduled at community centers, coffee shops, or other locations that are agreeable to me and all members of the team.
11. I understand that students will immediately notify 911 in medical and safety emergencies, as well as notify the Program Coordinator for the Community Health Mentor Program. My emergency contact person will then be notified by the coordinator.
12. I understand that students cannot provide or accept transportation under any circumstances and I will not offer to transport them.

13. I understand that students cannot give or accept gifts, gratuities, or loans from me or any member of my family and students may not purchase items for me or my family.
14. I understand that students are expected to act in a professional, courteous, and ethical manner at all times. If I feel a student is not acting appropriately, I will immediately contact the Program Coordinator at 602-827-2609 or [PBC-Mentor@email.arizona.edu](mailto:PBC-Mentor@email.arizona.edu)
15. I understand that 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, I understand that students will make a significant effort to maintain the privacy of my health related information. I also understand that my health information will be shared by students with faculty members as part of the learning process. If I believe there has been any kind of breach of my privacy under this paragraph, I will immediately contact the Program Coordinator at 602-827-2609 or [PBC-Mentor@email.arizona.edu](mailto:PBC-Mentor@email.arizona.edu)
16. I understand that the Community Health Mentor Program Coordinator may periodically schedule a visit with me to discuss any feedback I have.
17. I understand that students will be asking me questions about my medical and social history, my community, insurance coverage, home safety, nutrition, and other topics. This information will be collected for students to complete their assignments and to achieve their learning objectives. I acknowledge that while disclosing information is necessary to helping the students learn, I am not required to answer questions I do not feel comfortable with. In such cases, I will let the students know I am not comfortable answering a particular question. I also agree that I will not discuss religion, politics, gender orientation/sexual orientation, and race except as it pertains directly to my health and wellbeing.
18. I agree to complete feedback forms twice annually in regard to the Community Health Mentor Program.
19. I understand that the Community Health Mentor Program Coordinator reserves the right to dismiss me as a mentor at any time for any non-discriminatory reason.
20. I acknowledge that I am not *currently* pursuing a notice of claim or lawsuit against any university or health care professional.
21. I acknowledge that my participation in this program is contingent on the satisfactory completion of a criminal background check and that the results of that background check may make me ineligible to participate.
22. If I have any questions or concerns about this contract or the program at any time, I will contact the Program Coordinator at 602-827-2609 or by email at [PBC-mentor@email.arizona.edu](mailto:PBC-mentor@email.arizona.edu).

I acknowledge that I have received a copy of the Community Health Mentor Information Sheet. I have read and I agree to abide by the conditions set forth by this program and in this contract. I consent to participate as a Community Health Mentor in the Community Health Mentor Program and I understand I may withdraw from participation at any time. If I wish to withdraw from participation, I agree to contact the Program Coordinator at 602-827-2609 or [PBC-Mentor@email.arizona.edu](mailto:PBC-Mentor@email.arizona.edu).

**Mentor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Mentor Printed Name** \_\_\_\_\_

**For Mentor-Caregiver Teams**

Please sign and print your name below if you are the legal guardian or power of attorney for a participating mentor

**Legal Guardian or POA Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Legal Guardian or POA Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Please check and complete the appropriate box below:

I acknowledge that I \_\_\_\_\_ am the legal guardian of \_\_\_\_\_.

I acknowledge that I \_\_\_\_\_ am the power of attorney for \_\_\_\_\_.

DATE: \_\_\_\_\_

**Program Copy - Please Complete & Return**

**COMMUNITY HEALTH MENTOR INFORMATION**

Title (Mr., Mrs., Dr., etc.):		Preferred Pronouns:	
Name:		Primary Language:	
Best Contact Phone:		Alternate Phone:	
Email:			
Address:			
City:		State: AZ	ZIP Code:
Chronic Medical Condition(s)/Disability:			

I acknowledge that I have a Primary Care Provider and I know how to contact them.

**EMERGENCY CONTACT INFORMATION**

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

**PERSONAL INFORMATION**

**\*\*THE PERSONAL INFO SECTION IS OPTIONAL AND WILL NOT BE CONSIDERED IN EVALUATING PROGRAM ELIGIBILITY**

Gender:	Date of Birth:	Are you a Veteran?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Race/Ethnicity (check all that apply): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian				
<input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White				
How did you first hear about our program?				

**MEETING SETTINGS**

**\*\*\*MEETINGS WITH OUR STUDENTS MUST TAKE PLACE WITHIN 25 MINS OF DOWNTOWN PHOENIX**

Where do you plan to meet the students? <input type="checkbox"/> My Home <input type="checkbox"/> My Work <input type="checkbox"/> Public Location		
Work/Public Location Name (within 25 mins):		
Address:	City:	Zip:
What is the maximum number of students you can accommodate?		
Location Access/Information (Gate code to sub-division, special instructions, parking, etc.):		
Do you have pets? <input type="checkbox"/> Yes <input type="checkbox"/> No Does anyone smoke inside your home? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you have pets, please specify number and type of pet(s):		

**Please review and sign the Contract and complete the Contact Information form  
and save a copy for your records.**

**Please mail the completed forms to:**

**University of Arizona College of Medicine - Phoenix  
Health Sciences Education Building  
435 N. 5<sup>th</sup> St., 5th Floor, Room B503C  
Phoenix, AZ 85004**

**To fill out electronic copies of this paperwork instead, please contact us at:  
[PBC-mentor@email.arizona.edu](mailto:PBC-mentor@email.arizona.edu)**